No. 14-___

IN THE

Supreme Court of the United States

IN RE: MANAGED CARE LITIGATION

MEDICAL ASSOCIATION OF GEORGIA,
CALIFORNIA MEDICAL ASSOCIATION,
CONNECTICUT STATE MEDICAL SOCIETY,
STEPHEN D. HENRY, M.D.,
JAMES G. SCHWENDIG, M.D.,
CARMEN KAVALI, M.D.,

Petitioners,

v.

WELLPOINT, INC.

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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November 13, 2014

QUESTIONS PRESENTED

1. May a settlement agreement in a class action waive all class members' rights to pursue statutory remedies for the defendant's future violations of the federal antitrust laws, as a divided panel of the Eleventh Circuit held, or is such a waiver void because it violates the antitrust laws or public policy, as the Third, Fifth, Sixth, and Eighth Circuits have held, and as this Court stated in dicta in *Mitsubishi Motors Corp. v. Soler Chrysler–Plymouth, Inc.*, 473 U.S. 614 (1985), and *American Express Co. v. Italian Colors Restaurant*, 133 S. Ct. 2304 (2013)?

2. Can a federal antitrust cause of action be asserted before the occurrence of the acts and injuries from which the cause of action arises, as a divided panel of the Eleventh Circuit held, or does the cause of action accrue when the plaintiff is injured, as this Court held in *Lawlor v. National Screen Service Corp.*, 349 U.S. 322 (1955), and *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 401 U.S. 321 (1971)?

PARTIES TO THE PROCEEDING

Petitioners, who were plaintiffs in the district court and appellants in the court of appeals, are the Medical Association of Georgia; California Medical Association; Connecticut State Medical Society; Stephen D. Henry, M.D.; James G. Schwendig, M.D.; and Carmen Kavali, M.D.

Respondent WellPoint, Inc. was a defendant in the district court and the appellee in the court of appeals.

CORPORATE DISCLOSURE STATEMENT

The California Medical Association is a corporation with no parent corporation, and no publicly held company owns 10% or more of its stock.

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The opinion of the court of appeals (App. 1a–47a) is reported at 756 F.3d 1222. The order of the court of appeals denying rehearing (App. 84a–85a) is unreported. The report and recommendation of the magistrate judge (App. 48a–76a) is unreported but is available at 2010 U.S. Dist. LEXIS 142863. The orders of the district court adopting the magistrate judge's report and recommendation (App. 77a–78a), granting the defendant's motion for contempt (App. 79a–80a), and granting sanctions (App. 81a–83a) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on June 18, 2014. A petition for rehearing was denied on August 15, 2014. This court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

Section 4 of the Clayton Act, 15 U.S.C. § 15, provides in relevant part that "any person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor in any district court of the United States."

STATEMENT OF THE CASE

The federal statutory rights of most of the nation's physicians to protect themselves against anticompetitive conduct by some of the nation's largest health

insurers hang in the balance of this petition. A divided panel of the Eleventh Circuit effectively stripped these physicians of their rights in holding that releases contained in settlement agreements executed in a class action almost a decade ago precluded them from asserting federal antitrust claims based on conduct occurring years after the settlement agreements terminated. Under the Eleventh Circuit's reasoning, members of the previous class who are freshly injured by new anticompetitive conduct by the settling defendants have no legal recourse whatsoever.

The previous class action was filed in 1999, when several doctors and medical associations sued a number of health insurers for conspiring to manipulate their computer systems to underpay doctors for their services. The suits were transferred to the Southern District of Florida under the name *In re Managed Care*, No. 00-md-01334, and assigned to District Judge Federico A. Moreno. In 2005, one of the insurers, WellPoint, entered into a nationwide class settlement, which released WellPoint from claims

> arising on or before the Effective Date [of the settlement agreement], *that are, were or could have been asserted* against [WellPoint] by reason of, arising out of, or in any way related to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referenced in the [*Managed Care*] Actions . . . .

App. 5a, 87a (emphasis added).[1] In return for the release, WellPoint agreed to make a payment to each class member based on the class member's billings to WellPoint in the years prior to the settlement, and to reform its business practices for four years.

Judge Moreno approved the settlement in an order that permanently enjoined class members from participating in lawsuits based on released claims, and he retained jurisdiction over all matters relating to the interpretation of the settlement agreement and enforcement of its injunctions. App. 92a–95a. Judge Moreno also approved a notice to the class stating that the settlement could affect the rights of physicians who provided services to WellPoint's subscribers between August 4, 1990 and July 15, 2005. App. 6a. The effective date of the settlement, as defined in the agreement, was September 29, 2006. *See* App. 88a–89a. The settlement terminated, pursuant to its own terms, on July 19, 2009, four years after it was preliminarily approved. *See* App. 89a–91a.[2] Since this date, WellPoint has been under no obligation to abide by the reforms contained in the settlement agreement.

After the effective date of the settlement agreement, a group of doctors and medical associations,

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[1] The full text of the settlement agreement is available at Docket No. 4321 in *Managed Care*.

[2] In addition to WellPoint, several other insurers entered into substantially similar settlement agreements in *Managed Care* and a related case, *Love v. Blue Cross & Blue Shield Association*, No. 03-cv-21296 (S.D. Fla.). *See, e.g.*, *Managed Care* Docket No. 2000 (Aetna), Docket No. 2308 (Cigna), Docket No. 4552 (Humana); *Love*, Docket No. 928-1 (Blue Cross & Blue Shield), Docket No. 1073-1 (Highmark).

including the American Medical Association and California Medical Association, discovered that WellPoint was underpaying doctors by manipulating a database called Ingenix, which was supposedly a source of accurate information about the "usual, customary, and reasonable" rates of reimbursement for medical services. These "UCR" rates often determine how much an insurer pays a doctor who is not a member of the insurer's network of health care providers. In reality, the insurers "scrubbed" their submissions to Ingenix by removing the highest-value claims. Once the data were submitted, Ingenix removed even more high-value claims as statistical outliers. The insurers then used Ingenix's skewed data to calculate UCR rates that were deliberately set too low. For doctors, the result was chronic underpayment for their services.[3]

In 2009, the doctors and medical associations filed new suits against WellPoint, asserting claims under ERISA, RICO, and the Sherman Act. These suits were transferred to the Central District of California under the name *In re WellPoint, Inc. Out-of-Network "UCR" Rates Litigation*, No. 09-ml-02074 ("*WellPoint*"). The First Amended Complaint and all subsequent complaints filed in *WellPoint* expressly limited the claims of plaintiffs bound by the prior settlement agreement to those arising after September 29, 2006, the effective date of the agreement. *E.g.*, App. 109a–112a.[4]

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[3] For more details about these allegations, see *In re WellPoint, Inc. Out-of-Network "UCR" Rates Litigation*, 865 F. Supp. 2d 1002, 1016–17 (C.D. Cal. 2011).

[4] The full text of the First Consolidated Amended Complaint is available at Docket No. 12 in *WellPoint*.

The complaints in *WellPoint* contained numerous allegations of misconduct arising after the effective date of the settlement agreement in *Managed Care*. For example, the plaintiffs alleged that twice a year, Ingenix published a pricing database that it knew to be inaccurate, based on false data submitted by WellPoint. App. 96a–98a. The plaintiffs also alleged that WellPoint entered into a new agreement with Ingenix in 2008. App. 113a–114a. And the plaintiffs alleged that they provided and were undercompensated for medical services well after the effective date. App. 98a–109a. Thus, when doctors billed WellPoint for services they rendered in 2010, for example, WellPoint acted under an agreement it entered into with Ingenix *after* the effective date, submitted faulty data to Ingenix *after* the effective date, used a version of Ingenix created *after* the effective date, and underpaid Appellants *after* the effective date.

Even though the settlement agreement had expired, WellPoint returned to the Southern District of Florida and moved Judge Moreno to enjoin the *WellPoint* plaintiffs from pursuing their claims, which it argued were "Released Claims" under the *Managed Care* settlement. The motion was referred to a magistrate judge, who recommended that the *WellPoint* plaintiffs be enjoined. App. 48a–76a. Judge Moreno adopted the magistrate judge's report and recommendation, ordering the *WellPoint* plaintiffs to dismiss their claims or be held in contempt. App. 77a–78a.

The *WellPoint* plaintiffs offered to dismiss their claims in order to avoid being held in contempt if WellPoint would agree to a procedure for an appeal. WellPoint refused to do so, forcing the plaintiffs ei-

ther to forgo their right to be heard on appeal or to be held in contempt. The *WellPoint* plaintiffs appealed Judge Moreno's order to the Eleventh Circuit, and WellPoint moved to have the plaintiffs held in contempt. Judge Moreno granted the motion and later imposed monetary sanctions. App. 79a–80a, 81a–83a.[5]

On appeal, the *WellPoint* plaintiffs argued that the contempt order was invalid because it rested on erroneous holdings of law, two of which are relevant to this petition. The district court first erred in holding that the *Managed Care* settlement agreement, which released only those claims that "could have been asserted" as of the effective date of the settlement, released claims based on conduct that occurred *after* the effective date of the settlement. The second error was the district court's determination that the settlement agreement released the plaintiffs' antitrust claims in perpetuity, which would mean that the release itself violated public policy and was void.

A divided panel of the Eleventh Circuit affirmed in part, vacated in part, and remanded the case to Judge Moreno. App. 1a–47a. The panel unanimously agreed that the ERISA claims in *WellPoint* could not have been asserted as of the effective Date, and thus were not released, because they were based on medical services provided and underpayments received after the effective date. App. 27a–33a. The panel majority held, however, that the federal antitrust and RICO claims were released because "WellPoint's purported bad acts are best seen as new, overt acts

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[5] Some of the *WellPoint* plaintiffs dismissed their claims in order to avoid sanctions. Petitioners here are the *WellPoint* plaintiffs who did not dismiss their claims.

within an ongoing conspiracy, rather than new claims in and of themselves." App. 26a. The dissent argued that these claims were not released because the *WellPoint* plaintiffs "do allege new acts resulting in fresh underpayments," faulting the majority for failing to "extend the logic behind its recognition that the ERISA claims could not have been brought prior to the Effective Date" to the RICO and antitrust claims. App. 41a (Martin, J. dissenting).

The *WellPoint* plaintiffs timely petitioned the Eleventh Circuit for rehearing en banc, which was denied on August 15, 2014. App. 84a–85a.[6]

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[6] The *WellPoint* plaintiffs sought rehearing of the panel's decision with respect to their antitrust claims, but not their RICO claims. This petition is also limited to a request for review of the Eleventh Circuit's decision regarding the plaintiffs' antitrust claims.

REASONS FOR GRANTING THE PETITION

Civil suits "play[] a central role in enforcing" the antitrust laws, and "[t]he treble-damages provision wielded by the private litigant is a chief tool in the antitrust enforcement scheme, posing a crucial deterrent to potential violators." *Mitsubishi Motors Corp. v. Soler Chrysler–Plymouth, Inc.*, 473 U.S. 614, 635 (1985). Here, the Eleventh Circuit blunted this tool by limiting the plaintiffs' ability to challenge ongoing violations of the antitrust laws. The Eleventh Circuit majority departed from a half-century of clear precedent and four other courts of appeals when it held that the *WellPoint* plaintiffs had released their antitrust claims because

> the factual record clearly demonstrates that these claims could have been asserted at the time of the Effective Date, since all facts necessary to state a cause of action had occurred long before the Settlement Agreement took effect. The fact that Appellants seek to base the new claims on certain conduct post-dating the Effective Date does not change this conclusion. Because they merely constitute a continuation of the conspiracy alleged in [*Managed Care*], WellPoint's purported bad acts are best seen as new, overt acts within an ongoing conspiracy, rather than new claims in and of themselves.

App. 26a.

If the settlement agreement released claims based on "new, overt acts within an ongoing conspiracy," as the majority held, it would be void because it would violate the antitrust laws or public policy, as the Third, Fifth, Sixth, and Eighth Circuits have held,

and as this Court stated in dicta in *Mitsubishi Motors* and *American Express Co. v. Italian Colors Restaurant*, 133 S. Ct. 2304 (2013). *Mitsubishi Motors* stated that if a contract operates "as a prospective waiver of a party's right to pursue statutory remedies for antitrust violations, we would have little hesitation in condemning the agreement as against public policy." 473 U.S. at 637 n.19. Just last year, this Court reaffirmed that the principle enunciated in *Mitsubishi Motors* "would certainly cover a provision in an arbitration agreement forbidding the assertion of certain statutory rights." *Italian Colors*, 133 S. Ct. at 2310 (referring to the antitrust laws). The Eleventh Circuit has now created an exception to this principle for violations of the antitrust laws that take place "within an ongoing conspiracy," an exception no other court of appeals has ever recognized.

Moreover, the majority's holding that claims arising from "an ongoing conspiracy" may be released in perpetuity is a clear rejection of *Lawlor v. National Screen Service Corp.*, 349 U.S. 322 (1955), and *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 401 U.S. 321 (1971). In *Lawlor*, this Court held unanimously that a judgment following the settlement of an antitrust suit did not bar claims for acts the defendants committed after the judgment was entered, even if they committed those acts in furtherance of the same conspiracy alleged in the previous suit. In *Zenith*, the Court held that a plaintiff can state an antitrust cause of action only when the defendant's unlawful conduct injures him. Interpreting Section 4 of the Clayton Act, 15 U.S.C. § 15, which provides that an injury is a prerequisite to a private cause of action under the antitrust laws, the Court stated that "[i]n the context of a continuing conspiracy to violate the

antitrust laws, . . . this has usually been understood to mean that each time a plaintiff is injured by an act of the defendants a cause of action accrues to him to recover the damages caused by that act." 401 U.S. at 338. If a plaintiff's future damages are speculative, he does not have a cause of action until "the date they are suffered." *Id.* at 339.

Here, the majority acknowledged that the plaintiffs had alleged injuries resulting from "new, overt acts" after the effective date of the settlement agreement. In fact, some plaintiffs' *only* injuries resulted from these acts. It is impossible to square this Court's black-letter doctrine with the majority's holding that "all facts necessary to state a cause of action had occurred long before the Settlement Agreement took effect," even when "new, overt acts" caused the plaintiffs' injuries. App. 26a.

The significance of the Eleventh Circuit's decision is not limited to this case. Rather, it strips nearly one million physicians of their federal rights to challenge the continuing anticompetitive practices of many of the nation's largest health insurers in perpetuity, as many of those insurers have entered into settlements substantially similar to WellPoint's. Moreover, the decision injects uncertainty into countless other antitrust settlements that contain releases similar to the one the Eleventh Circuit considered here, and it threatens to expand *res judicata* in a way that would prevent plaintiffs from challenging ongoing antitrust conspiracies. Finally, the decision opens the door to a new abuse of the class action, in which absent class members find that they have given up the right to challenge ongoing conspiracies forever, without receiving compensation or notice that they are doing so. For these reasons, and because the Eleventh Cir-

cuit's decision conflicts with this Court's precedents and the decisions of four courts of appeals, Petitioners respectfully request that this Court grant certiorari.

I. The Eleventh Circuit Majority Interpreted the Settlement Agreement as a Prospective Waiver of Antitrust Claims, Which Would Violate the Antitrust Laws and Public Policy.

The Eleventh Circuit majority held that the *Managed Care* settlement agreement released antitrust claims for "new, overt acts within an ongoing conspiracy." App. 26a. Even if this were true, the release would be unenforceable because it would violate both the antitrust laws and public policy. As this Court stated in dictum in *Mitsubishi Motors*, if a plaintiff's agreement were to operate "as a prospective waiver of a party's right to pursue statutory remedies for antitrust violations, we would have little hesitation in condemning the agreement as against public policy." 473 U.S. at 637 n.19. As support for this statement, *Mitsubishi Motors* cited the page of *Lawlor* on which the Court stated that allowing a settlement agreement to confer "a partial immunity from civil liability for future violations" of the antitrust laws would be "consistent with neither the antitrust laws nor the doctrine of *res judicata*." *Mitsubishi Motors*, 473 U.S. at 637 n.19 (citing *Lawlor*, 349 U.S. at 329).

Mitsubishi Motors also cited decisions of the Fifth, Sixth, and Eighth Circuits, all of which held categorically that a party may not release claims for future violations of the antitrust laws. The first of these decisions, *Fox Midwest Theatres, Inc. v. Means*, 221 F.2d 173 (8th Cir. 1955), involved a conspiracy

among movie producers and distributors to harm a movie theater. The theater claimed that the conspiracy violated the antitrust laws, and the parties settled. *Id.* at 175. A year later, the theater's owners alleged that the producers and distributors were continuing to harm the theater in violation of the settlement agreement. *Id.* at 176. The issue before the court was whether the language of the settlement agreement released claims for "any continued or new, combinational or conspiratorial acts on the part of [the producers and distributors], such as [the theater owners] had charged them with having previously engaged in." *Id.* at 179. The court held that the language of the agreement was irrelevant to this issue because

> such rights needed no safeguarding against being prejudiced by the settlement agreement, for there was no way that appellees could at all, either intentionally or by legal import of any language used, have made the absolute and continuing obligation of non-combinational and non-conspiratorial conduct in trade imposed by the [antitrust laws] upon appellants the subject of any possible release or discharge as to the future.

Id. at 179–80. The court explained that "[a]ny contractual provision which could be argued to absolve one party from liability for future violations of the antitrust statutes against another would to that extent be void as against public policy" because such an agreement "would have impact, not simply between the parties, but upon the public as well" and could serve as a contract "in restraint of trade," which would violate the Sherman Act. *Id.* at 180. Therefore,

a settlement agreement "*could never and would never be read by any court* as having any possible legal effect as a release against further violation" of the antitrust laws. *Id.* (emphasis added).

The next decision that *Mitsubishi Motors* cited, *Gaines v. Carrollton Tobacco Board of Trade*, 386 F.2d 757 (6th Cir. 1967), also involved a dispute about whether the plaintiffs had agreed to settle prospective antitrust claims. Again, the court held that the record in the case was irrelevant because "it seems clear as a matter of law that such an agreement, if executed in a fashion calculated to waive damages arising from future violations of the antitrust laws, would be invalid on public policy grounds." *Id.* at 759 (citing *Fox Midwest Theatres*). The Sixth Circuit also relied on this Court's statement that

> [l]ocal rules of estoppel which would fasten upon the public as well as the petitioner the burden of an agreement in violation of the Sherman Act must yield to the Act's declaration that such agreements are unlawful, and to the public policy of the Act which in the public interest precludes the enforcement of such unlawful agreements.

Sola Elec. Co. v. Jefferson Elec. Co., 317 U.S. 173, 177 (1942).

Finally, *Mitsubishi Motors* cited *Redel's, Inc. v. General Electric Co.*, 498 F.2d 95 (5th Cir. 1974). The question in *Redel's* was whether a general release could absolve a defendant of liability for price discrimination that took place after the release was executed. The Fifth Circuit was unequivocal: "Releases

may not be executed which absolve a party from liability for future violations of our antitrust laws." *Id.* at 99.[7] As the Sixth Circuit did in *Gaines*, the Fifth Circuit cited the Eighth Circuit's statement in *Fox Midwest Theatres* that such a release could serve as an illegal contract in restraint of trade. *Id.*

In addition to these three circuits, the Third Circuit also has adopted this reasoning. *Three Rivers Motors Co. v. Ford Motor Co.*, 522 F.2d 885, 896 n.27 (3d Cir. 1975) ("We agree with those courts which have held that there is nothing in the public policy behind antitrust laws that prohibits general releases encompassing antitrust claims, provided that the release does not seek to waive damages from future violations of antitrust laws.") (citing *Gaines* and *Redel's*).

When it held that the *WellPoint* plaintiffs had released claims for future violations of the antitrust laws, the Eleventh Circuit majority departed from all of these opinions. Acknowledging the dissent's argument that the settlement agreement "did not protect WellPoint for any misconduct for all time," the majority wrote, "The crux of our disagreement, however, is that Judge Martin believes that the allegations in [*WellPoint*] indicate 'new, wrongful conduct' whereas we view the conduct as being a continuation of the

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[7] Decisions of the Fifth Circuit prior to October 1, 1981 are binding precedent in the Eleventh Circuit. *Bonner v. City of Prichard*, 661 F.2d 1206 (11th Cir. 1981). Because the Eleventh Circuit's decision here departs from *Redel's* by allowing a party to waive claims for future violations of the antitrust laws that occur in an ongoing conspiracy, it has created a split with the Fifth Circuit, which has never recognized such an exception to *Redel's*.

same conduct raised in [*Managed Care*]." App. 32a–33a. In effect, the majority created a new exception to *Redel's*, as well as the decisions of the Third, Sixth, and Eighth Circuits described above, for conduct that amounts to "new, overt acts within an ongoing conspiracy." App. 26a. This exception would swallow the rule; if there is any future misconduct that should not be subject to release, it is the very misconduct that caused the plaintiffs to file suit in the first place. As the dissent put it, "WellPoint argues that the Physicians 'do not suggest . . . WellPoint began doing something different or new that it had not been doing before.' But this argument ignores that WellPoint agreed to quit doing what it had done before." App. 41a (Martin, J., dissenting) (alteration in original). The dissent was correct; a settlement should not be an opportunity for a defendant to gain eternal protection for its ongoing unlawful practices.

II. The Majority's Holding That the Plaintiffs' Claims "Could Have Been Asserted" Before the Plaintiffs Were Injured Conflicts with *Lawlor* and *Zenith*.

The settlement agreement in *Managed Care* released claims only if they "are, were or could have been asserted" as of the agreement's effective date. App. 5a, 87a. The Eleventh Circuit contravened this Court's precedent when it held that the claims in *WellPoint*, which arose from acts and injuries occurring after the effective date, "could have been asserted" as of the effective date.

The facts of this case closely resemble those of *Lawlor*, in which the plaintiffs, who leased movie posters to theaters, sued three movie producers and

a distributor of movie posters for conspiring to establish a monopoly in the distribution of movie posters. 349 U.S. at 323–24. The parties settled, and the suit was dismissed with prejudice. *Id.* at 324. The settlement agreement required the defendants to make movie posters available to the plaintiffs at specified prices. *Id.* Six years later, the plaintiffs sued the same defendants again, alleging that their conspiracy continued after the effective date of the settlement agreement, and seeking an injunction and treble damages. *Id.* Because the settlement and dismissal in the first suit barred any subsequent suit based on the same cause of action under the doctrine of *res judicata*, the plaintiffs could pursue the second suit only if it was not based on the same cause of action. *Id.* at 326–27. The district court held that the second suit was barred, and the Third Circuit affirmed. *Id.* at 325–26.

The Third Circuit's reasoning in *Lawlor* was identical to the Eleventh Circuit majority's reasoning here:

> [I]f the plaintiff complains about a conspiracy, asks for damages for acts done pursuant thereto and to have the conspiracy stopped by injunction, when he loses that lawsuit by judgment is he barred from thereafter claiming damages for other acts, or further acts, which he says are done in furtherance of the original conspiracy? We think he is . . . .

Lawlor v. Nat'l Screen Serv. Corp., 211 F.2d 934, 936 (3d Cir. 1954). The Third Circuit agreed with the district court that the plaintiffs were asserting "essentially the same course of wrongful conduct" in both suits:

> It is true that there are some additional allegations, some new acts which the plaintiffs say the defendants have done since the earlier suit. But we think in substance the complaint is the same and that what plaintiffs object to is an alleged combination of the defendants to do illegal things harmful to the plaintiffs' business and acts done pursuant to that combination.

Id. at 936–37. There is no difference between these statements and the Eleventh Circuit majority's holding that

> [t]he fact that Appellants seek to base the new claims on certain conduct post-dating the Effective Date does not change [our] conclusion. Because they merely constitute a continuation of the conspiracy alleged in [*Managed Care*], WellPoint's purported bad acts are best seen as new, overt acts within an ongoing conspiracy, rather than new claims in and of themselves.

App. 26a.

This Court granted certiorari in *Lawlor* "because of the importance of the question thus presented in the enforcement of the federal antitrust laws," 349 U.S. at 326, and reversed the Third Circuit unanimously, *id.* at 330. "That both suits involved 'essentially the same course of wrongful conduct," the Court held, "is not decisive." *Id.* at 327. "Such a course of conduct – for example, an abatable nuisance – may frequently give rise to more than a single cause of action. And so it is here. The conduct presently complained of was all subsequent to the [earlier] judgment." *Id.* at 327–28. And so it is here as well: the *WellPoint* complaint limited itself to

claims for injuries caused by WellPoint's conduct after the effective date of the *Managed Care* settlement. As the dissent recognized, *Lawlor* provides that "WellPoint remains 'on the hook' for any new bad acts it commits after the Effective Date. And it is only new actions, taking place after the Settlement Agreement, which are at issue in [*WellPoint*]." App. 42a–43a.

The Eleventh Circuit's holding that the claims in *WellPoint* "could have been asserted" as of the effective date, even though they were based on "new, overt acts within an ongoing conspiracy" committed after the effective date, also conflicts with this Court's holding in *Zenith* that federal antitrust claims accrue with each injurious overt act in furtherance of the continuing conspiracy: "In the context of a continuing conspiracy to violate the antitrust laws . . . each time a plaintiff is injured by an act of the defendants a cause of action accrues to him to recover the damages caused by that act . . . ." 401 U.S. at 338. The question in *Zenith* was whether, in a suit filed in 1963, the plaintiff could recover damages suffered from 1959 to 1963 as a result of pre-1954 conspiratorial conduct. *Id.* To answer this question, the Court considered whether the plaintiff could have recovered those damages in a suit brought in 1954. *Id.* at 340. Applying the "hornbook" principle "that even if injury and a cause of action have accrued as of a certain date, future damages that might arise from the conduct sued on are unrecoverable if the fact of their accrual is speculative or their amount and nature unprovable," *id.* at 339, the Court concluded that the plaintiff's claims were timely because "[c]laims of future damage would have probably gotten short shrift in the lower courts if they had been pressed in this case," *id.* at 342. Therefore, a plaintiff

has no cause of action until "the date [the damages] are suffered." *Id.* at 339.[8]

Likewise, the *WellPoint* plaintiffs would have "gotten short shrift" if they had tried to assert their claims in September 2006, when the *Managed Care* settlement agreement became effective. The *WellPoint* complaint alleged injuries that WellPoint caused only after the effective date of the *Managed Care* settlement agreement. App. 109a–112a. For example, before the effective date in 2006, WellPoint's use of the Ingenix database had not injured *WellPoint* plaintiff Carmen Kavali because she was a member of WellPoint's network of health care providers, and WellPoint's use of Ingenix affected only out-of-network providers.[9] For this reason, she received no compensation in the *Managed Care* settlement with WellPoint. In 2007, after the effective date, Dr. Kavali left WellPoint's network, and WellPoint began to reimburse her as an out-of-network physician. App. 106a. Dr. Kavali alleged that in 2007 and 2008, WellPoint unlawfully reduced its reimbursements for surgeries she performed, concealing that it was relying on manipulated data in the Ingenix database, which was generated after the effective date of the *Managed Care* settlement agreement, App. 107a–109a, based on data that WellPoint and other insurers submitted to Ingenix after that date, App. 96a–98a.

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[8] Petitioners cited *Lawlor* and *Zenith* in their opening brief in the Eleventh Circuit. The majority's opinion cited neither.

[9] Dr. Kavali was nevertheless a member of the class in *Managed Care*, which included all physicians who provided services to WellPoint's patients between 1990 and 2005, and she is bound by the district court's orders in that case.

The majority acknowledged that claims like Dr. Kavali's were based on "new, overt acts," but held nevertheless that these claims "could have been asserted" in 2006, even though the conduct that gave rise to the plaintiffs' injuries did not occur until 2007 or later. But in 2006, Dr. Kavali would have had to allege that, years in the future, 1) she would leave WellPoint's network, 2) she would continue to treat WellPoint subscribers on an out-of-network basis, 3) WellPoint would submit manipulated data to the Ingenix database, 4) Ingenix would publish new, false data, and 5) WellPoint would knowingly rely on those false data to underpay her. There is no way such a claim "could have been asserted"; it would have been dismissed out of hand as speculative.

The dissent pointed out this flaw in the majority's reasoning, noting that the majority held that the *WellPoint* plaintiffs' claims under ERISA, which were based on the same conduct as their antitrust claims, could not have been brought prior to the effective date of the settlement agreement. App. 41a (Martin, J., dissenting.) The majority erred, then, when it did not "extend the logic behind its recognition that the ERISA claims could not have been brought prior to the Effective Date . . . to the remainder of claims brought by the Physicians in [*WellPoint*]." *Id.*

The majority's only other justification for its decision—that the *WellPoint* plaintiffs could have asked the *Managed Care* court to enforce the settlement agreement, rather than filing a new suit—was clearly incorrect. App. 33a. First, the majority was well aware that the settlement agreement had expired in

July 2009.[10] When the *WellPoint* plaintiffs filed their First Amended Consolidated Complaint in December 2009—the complaint for which Judge Moreno held them in contempt—there was nothing left for the plaintiffs to enforce. Second, this Court held unanimously in *Lawlor* that the availability of injunctive relief in an antitrust action does not bar future claims for treble damages based on similar conduct: "[R]espondents' novel contention" that the petitioners could not assert a claim for damages caused by ongoing antitrust violations because they did not seek injunctive relief in an earlier suit "would in effect confer on them a partial immunity from civil liability for future violations." 349 U.S. at 329.

III. This Case Deserves Certiorari Because It Involves Important Federal Issues for Which Nationwide Uniformity Is Crucial.

When this Court granted certiorari in *Lawlor*, it did so "because of the importance of the question thus presented in the enforcement of the federal antitrust laws." 349 U.S. at 326. Because the Eleventh Circuit majority made the same mistake that the Third Circuit did in *Lawlor*, the case for certiorari is just as strong here.

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[10] Oral Argument at 7:47–8:52 (plaintiffs' counsel explaining that the *WellPoint* plaintiffs could not have enforced the settlement agreement, which ended in 2009); 21:50–22:11 (Judge Jordan, who was in the majority, asking a question about hypothetical events occurring "after the consent decree ended"). Although the settlement agreement expired in 2009, the *Managed Care* plaintiffs are permanently enjoined from asserting claims that were released in the settlement agreement.

The Eleventh Circuit's decision has tremendous implications for the nearly one million physicians—most of the physicians in the country—who are bound by WellPoint's settlement agreement or similar settlement agreements with other large insurers. If WellPoint or one of the other insurers wants to participate in an ongoing conspiracy to underpay doctors for their services, it now has a blank check. A young doctor who became licensed to practice shortly before these settlement agreements were signed can be the victim of an ongoing antitrust conspiracy for nearly her entire career, without any recourse under the antitrust laws, whether or not she received compensation in the *Managed Care* settlement. Such a "partial immunity from civil liability for future violations," this Court held in *Lawlor*, is inconsistent with the antitrust laws. 349 U.S. at 329.

The implications of the majority's decision extend beyond physicians, however. By holding that claims based on "new, overt acts within an ongoing conspiracy" "could have been asserted" before those acts were committed, the majority has undermined nationwide uniformity in the interpretation of settlement agreements, which commonly release claims that "could have been asserted" as of a certain date.[11]

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[11] For example, Apple recently entered into a $450 million settlement of claims that it conspired with publishers to restrain trade in e-books. Like the settlement agreement here, Apple's settlement agreement releases claims "that were asserted or could have been asserted" as of the effective date of the settlement. *In re Elec. Books Antitrust Litig.*, No. 11-md-2293 (S.D.N.Y.), Docket No. 642-1 at 21. *See also CLRB Hanson Indus., LLC v. Google, Inc.*, No. 05-cv-3649 (N.D. Cal.), Docket No. 315-2 at 9 (releasing claims relating to Google's AdWords program that "were or could have been asserted"); *In re TFT-*

That language now means something different in the Eleventh Circuit than it does elsewhere, even though these agreements often apply to plaintiffs nationwide. Litigants who have included this language in their settlement agreements cannot know for sure what their releases mean.

The majority's decision also opens the door to new abuses in class actions because it permits counsel to craft settlement agreements that eliminate absent class members' rights to challenge ongoing conspiracies without compensating those class members or giving them notice that their release is so broad. Here, the district court approved a class notice directed toward physicians who provided services "between August 4, 1990 and July 15, 2005." App. 6a. Neither this statement nor anything else in the class notice alerted absent class members that if they did not opt out, they would be giving up, for all time, their right to sue WellPoint for ongoing violations of the antitrust laws. The dissent explained that "[p]hysicians who had not yet provided the relevant services, but might do so in the future, would understandably believe this notice had no relevance to them." App. 42a (Martin, J., dissenting). And many of these absent class members received no compensation because they were not injured until long after the settlement agreement became effective. Neither Rule 23 nor due process allows absent class members to forgo their statutory rights without notice or compensation. *See Twigg v. Sears, Roebuck & Co.*, 153

LCD (Flat Panel) Antitrust Litig., No. 07-md-1827 (N.D. Cal.), Docket No. 7685 at 5 (releasing claims relating to a price-fixing conspiracy in the market for display panels that "could have been asserted").

F.3d 1222, 1227 (11th Cir. 1998) (holding that due process requires that class notice "contain information reasonably necessary to make a decision to remain a class member and be bound by the final judgment or opt out of the action").

The majority's decision also threatens to create an unwarranted expansion of the doctrine of *res judicata*, by which "a final judgment on the merits of an action precludes the parties or their privies from relitigating issues that were or could have been raised in that action." *Allen v. McCurry,* 449 U.S. 90, 94 (1980); *accord Mann v. Palmer*, 713 F.3d 1306, 1311 (11th Cir. 2013) (among the requirements of *res judicata* is that the claim in a new suit "was or could have been raised in the prior action"). The majority's holding that claims based on "new, overt acts within an ongoing conspiracy" "could have been asserted" before those acts were committed leads to bizarre results. For example, suppose that a defendant harms a plaintiff in the course of an antitrust conspiracy, but the plaintiff is unable to muster enough evidence to prove his claim and loses on summary judgment. If the conspiracy continues to injure the plaintiff, and the plaintiff later discovers iron-clad evidence of the ongoing conspiracy, any new cause of action will be barred by *res judicata* because it "could have been asserted" in the previous suit, according to the Eleventh Circuit. The defendant will now be able to pursue its conspiracy with impunity. This is the type of result that this Court's decision in *Lawlor* was meant to avoid. 349 U.S. at 329 ("Acceptance of the respondents' novel contention would in effect confer on them a partial immunity from civil liability for future violations. Such a result is consistent with neither the antitrust laws nor the doctrine of *res judicata*.").

The threat to *res judicata* is more than a theoretical concern. In a case called *Musselman v. Blue Cross & Blue Shield of Alabama*, the Eleventh Circuit is now considering whether a similar release in a related case against other health insurers bars physicians from asserting claims of an ongoing conspiracy among these insurers to allocate geographic markets among themselves. No. 13-14250-AA (11th Cir.). Judge Moreno, who issued the first decision in this case, held that the release did bar such claims, even though claims of market allocation were never at issue in the previous case, and even though the plaintiffs in *Musselman* alleged injuries arising from acts occurring after the effective date of the settlement agreement. *Musselman v. Blue Cross & Blue Shield of Ala.*, No. 13-cv-20050, 2013 U.S. Dist. LEXIS 117828 (S.D. Fla. Aug. 20, 2013). The plaintiffs appealed. After *Musselman* was briefed in the Eleventh Circuit, that court issued its decision in this case. The appellees filed a notice citing the majority's opinion as authority that claims of market allocation were barred because they "could have been asserted" in the earlier litigation. App. 115a–117a. Thus, litigants are already using the Eleventh Circuit's opinion here to attempt to enjoin claims that were not litigated in previous suits and that arose from acts and injuries occurring after those suits ended.

Certiorari is particularly important here because it is unlikely that the Eleventh Circuit will revisit its holding anytime soon. When the *WellPoint* plaintiffs petitioned for rehearing en banc, none of the ten judges in active service requested a poll of the court. In many ways, this case resembles *Palmer v. BRG of Georgia, Inc.*, 498 U.S. 46 (1990), in which the Eleventh Circuit, in a divided opinion, essentially created new exceptions to this Court's holdings that horizon-

tal price fixing and horizontal territorial allocation are unlawful *per se*. The appellants petitioned for rehearing en banc, but no judge requested a poll. *Palmer v. BRG of Ga., Inc.*, 893 F.2d 293 (11th Cir. 1990). Although neither the opinion of the Eleventh Circuit nor this Court's subsequent opinion suggested the existence of a circuit split, this Court granted certiorari and summarily reversed. *Palmer*, 498 U.S. at 50. Here too, the uniform enforcement and interpretation of the antitrust laws depend on this Court.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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November 13, 2014

APPENDIX

APPENDIX A

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

[Filed 6/18/2014]

No. 12-14013
D.C. Docket No. 1:00-md-01334-FAM

In Re: MANAGED CARE, *et al*.

MEDICAL ASSOCIATION OF GEORGIA, CALIFORNIA MEDICAL ASSOCIATION, *et al*.,
Plaintiffs-Appellants,
v.
WELLPOINT, INC.,
Defendant-Appellee.

Appeal from the United States District Court
for the Southern District of Florida

June 18, 2014

Before MARTIN and JORDAN, Circuit Judges, and BAYLSON,* District Judge. BAYLSON, District Judge:

I. INTRODUCTION

The issue before us is whether the District Court abused its discretion in finding Appellants in contempt for violating the terms of a prior Settlement Agreement.

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* Honorable Michael M. Baylson, United States District Judge for the Eastern District of Pennsylvania, sitting by designation.

Underlying this overarching issue is a complex, twelve-year-old, multidistrict litigation; a related multidistrict litigation pending in another federal district court; and whether the District Court reasonably interpreted the Settlement Agreement in the first action.

A. MDL 1334

In 2000, a number of physicians and physician associations initiated a group of class actions against various providers of health plans, which were consolidated into a multidistrict litigation and assigned to the Southern District of Florida ("District Court"). *In re Managed Care Litig.*, No. 1:00-md-01334 (S.D. Fla. Apr. 17, 2000) ("MDL 1334"). The parties settled that lawsuit in 2005, resulting in a Settlement Agreement and an Order issued by the Southern District of Florida approving that Settlement Agreement.

B. The UCR MDL

In 2009, another group of physicians and physician associations—including Appellants—filed multiple lawsuits against, Appellee, WellPoint, Inc. ("WellPoint"), which were consolidated into a multidistrict litigation in the Central District of California. *In re WellPoint, Inc. Out-of-Network "UCR" Rates Litig.*, No. 2:09-ml-02074 (C.D. Cal. Aug. 20, 2009) ("UCR MDL").

C. The Present Dispute

The present dispute involves the propriety of the District Court's Order holding Appellants in contempt and imposing sanctions for the violation of an injunction. An earlier Order from the District Court barred Appellants from pursuing their claims in the UCR MDL, because the District Court found that the claims had been released by the Settlement

Agreement reached by the parties in MDL 1334. When Appellants refused to withdraw those claims as directed, the District Court held Appellants in contempt and imposed sanctions.

For the reasons stated below, we affirm the judgment of the District Court in large part, but vacate the Injunction as to Appellants' ERISA claims insofar as they hinge on the denial or underpayment of benefits following the Settlement Agreement's Effective Date (as defined below), and remand to the District Court for a determination of which ERISA claims can proceed in view of this opinion and for reconsideration of the imposition of sanctions.

II. PROCEDURAL HISTORY

A. MDL 1334

1. *MDL 1334 Allegations*

In 2000, physicians and physician associations initiated an action in the Southern District of Florida against a group of healthcare insurance companies, including WellPoint, on behalf of a nationwide class of physicians. This action was later consolidated into a multidistrict litigation in April 2000. The class representatives alleged that these insurance companies engaged in a conspiracy by means of mail and wire fraud to inflate profits by systematically denying, delaying, and diminishing payments due to them and that "the conspiracy was conducted through and implemented by" several means, including "the development and utilization of automated and integrated claims processing and other systems such

as those generated by" the company Ingenix.[1] MDL 1334 D.E. 1607 ¶ 120.[2]

2. *Settlement Agreement*

In 2005, WellPoint settled the MDL 1334 claims on a national, class-wide basis, agreeing to pay $198 million to the class and class counsel and promising to make a wide range of changes to its business practices, including changes to the method used to determine usual, customary, and reasonable ("UCR") rates. MDL 1334 D.E. 4321 ("Settlement Agreement") §§ 7, 8.1, 8.2, 9.1, 16. WellPoint specifically "agree[d] that, to the extent it uses Physician charge data to determine the usual, reasonable, and customary amount to be paid for services performed by Non-Participating Physicians, it will not use any internal claims database" that systematically underprices claims. Settlement Agreement § 7.14(d).

In exchange, the class agreed to release all claims related to the allegations underlying MDL 1334 once the Settlement Agreement took effect. Section 13.1(a)

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[1] Ingenix is a nationwide healthcare information company that sells pricing schedules to medical providers, healthcare insurers, and others. UCR MDL D.E. 113 (Second Consol. Am. Compl.) ¶ 116. Ingenix creates its pricing schedules by relying on its database, which compiles provider charge data regarding various medical procedures throughout the country that it receives from health insurance companies. *Id.* ¶ 103-113. The Second Consolidated Amended Complaint alleges that the conspirators used and manipulated the Ingenix database to systematically under-reimburse for services. *Id*. ¶ 114.

[2] We adopt the above citation method to differentiate between citations to the two different MDL dockets. Throughout this opinion, where we cite to page numbers of docket entry items, we refer to the ECF generated page number.

of the settlement agreement defines a "released claim" and provides:

> [Released Parties shall be released] from any and all causes of action, judgments, liens, indebtedness, costs, damages, obligations, attorneys' fees, losses, claims, liabilities and demands of whatever kind or character (each a "Claim"), arising on or before the Effective Date, that are, were or could have been asserted against any of the Released Parties by reason of, arising out of, or in any way related to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referenced in the Actions . . . .

Id. § 13.1(a). The next subsection, applicable only to claims against the Blue Cross Blue Shield Association ("BCBSA"), further provided that:

> The Releasing Parties further agree to forever abandon and discharge any and all Claims that exist nor or that might arise in the future against BCBSA . . ., which Claims arise from, or are based on, conduct by any of the Released Parties that occurred on or before the Effective Date and are, or could have been, alleged in the Complaints, whether any such Claim was or could have been asserted by any Releasing Party on its own behalf or on behalf of other Persons.

Id. § 13.1(b).

The Settlement Agreement further provides:

> Each Class Member who has not validly and timely requested to Opt-Out of this

> Agreement and each Signatory Medical Society may hereafter discover facts other than or different from those which he, she or it knows or believes to be true with respect to the claims which are the subject matter of the provisions of § 13, but each such Class Member and each Signatory Medical Society hereby expressly waives and fully, finally and forever settles and releases, upon the entry of Final Order and Judgment, any known or unknown, suspected or unsuspected, contingent or non contingent claim with respect to the subject matter of provisions of § 13, whether or not concealed or hidden, without regard to the discovery or existence of such different or additional facts.

Id. § 13.5(b).

3. *Notice to Class Members*

The District Court preliminarily approved the settlement, MDL 1334 D.E. 4336, and notice was mailed to potential class members in August 2005. The notice stated:

> IF YOU ARE A PHYSICIAN WHO PROVIDED COVERED SERVICES TO ANY INDIVIDUAL ENROLLED IN OR COVERED BY CERTAIN HEALTH CARE PLANS AT ANY TIME BETWEEN AUGUST 4, 1990 AND JULY 15, 2005 . . . PLEASE READ THIS NOTICE CAREFULLY.

MDL 1334 D.E. 4608 at 62.

In the section describing the claims released against WellPoint, the notice stated that they consisted of claims "arising on or before the date that the Court's

order approving the settlement becomes final, that are, were or could have been asserted." *Id.* at 65. The next sentence added that certain "claims that exist now or that might arise in the future" are waived against the Blue Cross and Blue Shield Association ("BCBSA"). *Id.* The notice also stated that the District Court would hold a hearing in which it "will consider whether to enter orders that would prevent members of the Class and certain other persons, including the Defendants in the Actions other than WellPoint, from asserting certain claims against WellPoint in the future." *Id.* at 66. The notice further described how to obtain additional information about the proposed settlement.

4. *Approval of Settlement Agreement*

In November 2005, one month after the deadline for filing objections or opting out of the class, the parties filed a joint motion for the court's final approval of the settlement. MDL 1334 D.E. 4608. Among other things, the joint motion: (1) recited the obligation of the insurance companies to change their business practices, *Id.* at 10-17; (2) asked the District Court to overrule the limited objections filed by class members, *Id.* at 29-49; and (3) advised the District Court that one objector was "simply wrong that the release [was] too broad," *Id.* at 44.

The District Court approved the Settlement Agreement in an Amended Order issued on January 3, 2006. MDL 1334 D.E. 4684 (the "Injunction"). The Order enjoined the class members—"Released Parties" under the Settlement Agreement—from participating in lawsuits "arising out of or relating in any way to the Released Claims." *Id.* ¶¶ 2, 5, 18. Generally tracking the language in the class notice, the amended order approving the settlement noted that the agreement

released claims "that exist now or that might arise in the future against BCBSA," *id.* ¶ 6, and released claims against WellPoint "that are, were or could have been asserted against any of the Released Parties by reason of, arising out of, or in any way related to" the facts at issue in MDL 1334. *Id.* ¶ 5. The District Court retained jurisdiction on "all matters relating to (a) the interpretation, administration, and consummation of the Settlement Agreement and (b) the enforcement of the injunctions described." *Id.* ¶ 27.

B. UCR MDL

In 2009, Appellants—three medical associations and three physicians, who had been members of the settlement class in MDL 1334—joined with other plaintiffs to file multiple lawsuits against WellPoint regarding alleged underpayment for the provision of medical services. The Judicial Panel on Multidistrict Litigation consolidated those lawsuits into the UCR MDL, a separate multidistrict litigation in California. Plaintiffs filed the First Consolidated Amended Complaint on November 2, 2009, in which the physicians brought ERISA claims under § 1132(a)(1)(B), the medical associations brought various state law claims, and all plaintiffs brought RICO and antitrust claims. UCR MDL D.E. 12.

The UCR MDL plaintiffs then filed a Motion for Leave to File a Second Consolidated Amended Complaint on June 28, 2010. UCR MDL D.E. 113. On July 12, 2010, the district court granted the plaintiffs' motion and deemed the Second Consolidated Amended Complaint filed as of that day. UCR MDL D.E. 124. The Second Consolidated Amended Complaint reiterated the allegations of the First Amended Consolidated Complaint, setting forth allegations that WellPoint had engaged in a conspiracy with

other managed care companies to systematically set artificially reduced rates by using the Ingenix database to price claims, thus under-reimbursing physicians for certain medical services, in violation of the Sherman Act, ERISA, and various state laws.[3] UCR MDL D.E. 113-1. Specifically, the Second Consolidated Amended Complaint alleged that:

- Defendants and the Conspirators entered into secret and intentionally concealed agreements to depress reimbursements for [out-of-network services or "ONS"]. The conspiracy and illegal conduct result in invoicing of inflated and improper charges to and out-of-pocket payments made by and for healthcare providers. The conspiracy and illegal conduct also results in underpayment of healthcare providers for services rendered . . . *Id.* ¶ 67.
- Plaintiffs' claims in this case are directed at a secret, illegal agreement and deceptive scheme involving Defendants and most of the country's largest health insurers to systematically under-reimburse for ONS. During the Relevant Time Period [defined as "1998 to the present," *Id.*

[3] The allegations at issue in MDL 1334 covered a broader range of conduct than the UCR MDL. Nevertheless, at least some of the allegations in MDL 1334 closely relate to the UCR MDL allegations currently at issue. For example, in language very similar to the UCR MDL allegations, the MDL 1334 plaintiffs alleged that WellPoint and others engaged in an "automated scheme to deny and reduce payments to doctors" that was "conducted through and implemented by . . . the development and utilization of automated and integrated claims processing and other systems such as those generated by . . . Ingenix . . . and the configuration and use of such systems to similarly deny, diminish and delay payments to physicians . . . ." MDL 1334 D.E. 4661 (Third Amended Consolidated Class Action Complaint) ¶¶ 82-83.

¶ 26], the Insurer Conspirators agreed to fix the UCRs used to reimburse for ONS at artificially low levels. Pursuant to this agreement, Defendants and their Conspirators knowingly created a flawed system that uses limited amounts of manipulated data to artificially depress reimbursement rates for ONS. *Id.* ¶ 70.

- Unbeknownst to Plaintiffs, healthcare consumers and providers nationwide, Defendants and the Conspirators have conspired to ensure that the UCR pricing schedules generated by Ingenix are artificially low ("False UCRs"). When the Insurer Conspirators then use those schedules to calculate ONS reimbursements, the resulting payments to subscribers and providers are artificially low and substantially below the actual UCR for similar services in the relevant geographic area. *Id.* ¶ 72.
- Defendants engaged in price fixing when they agreed with their Conspirators to utilize precisely the same flawed database to determine the UCR amounts for out-of-network medical services, which lead to them paying substantially reduced amounts for services rendered to their subscribers. *Id.* ¶ 86.
- The way in which the Ingenix Database has operated and continues to operate, and the manner in which the Insurer Conspirators utilize the Ingenix Database, demonstrate that the anticompetitive agreement to establish False UCRs persists to the present. *Id.* ¶ 115.
- WellPoint breached its fiduciary duties by failing to disclose the actual and true reimburse-

ment rules used to pay ONS benefits by knowingly using inaccurate, flawed and fabricated data from the Ingenix Database to calculate UCRs, by knowingly delegating their duty to collect accurate information regarding UCRs to Ingenix (whom WellPoint knew was collecting inadequate and inaccurate data regarding UCRs), and by failing to fulfill its obligations of good faith, due care and loyalty. Moreover WellPoint breached its duties by manipulating the data it used to pay ONS so as to artificially depress the data Ingenix relied upon in creating UCR schedules for ONS reimbursements. *Id.* ¶ 178.

- In processing claims of ONS charges, WellPoint is obligated under ERISA to calculate accurate UCRs and reimburse subscribers accurately ICRs in a manner consistent with the definition of UCR used by WellPoint to describe its health plans to its plan subscribers. WellPoint does not fulfill this obligation because it fails to pay benefits based on accurate UCRs. *Id.* ¶ 196.

- The WellPoint-Ingenix Enterprise was formed in 1998, at the time of the sale of the PHCS database by HIAA to Ingenix," and "[a]t all relevant times, the Enterprise was engaged in, and its activities affected, interstate commerce within the meaning of RICO, 18 U.S.C. § 1962(c). *Id.* ¶ 291.

C. Motion to Enjoin UCR MDL Plaintiffs

WellPoint took the position that both the Settlement Agreement reached in MDL 1334, and the District Court's January 3, 2006 Order approving that Settlement Agreement, barred the UCR MDL

plaintiffs from pursuing their claims in the UCR MDL. WellPoint thus filed a Motion to Enforce the Injunction Against Physician Plaintiffs in the Southern District of Florida, seeking to enforce that January 3, 2006 Order against the UCR Plaintiffs. MDL 1334 D.E. 6053.

2. UCR Plaintiffs Ordered to Withdraw Claims

On August 15, 2010, after consideration of WellPoint's Motion to Enforce the Injunction, MDL 1331 D.E. 6053, Magistrate Judge Torres issued a Report and Recommendation ("R&R"), recommending that the District Court grant WellPoint's Motion and order the California MDL plaintiffs, including Appellants, to withdraw their claims.[4] MDL 1334 D.E. 6116. Judge Torres found that, "as indicated by the broad release language of the Settlement Agreement, Plaintiffs have released all of their claims based on WellPoint's alleged improper UCR calculations . . . ." *Id.* at 17. Pursuant to this understanding, Judge Torres also found that "the RICO and antitrust claims clearly fall within the scope of Released Claims . . . because they all relate to WellPoint's conspiracy to systematically under-compensate the non-participating parties," *Id.* at 10, and that

[4] In 2009, Judge Torres issued two related R&Rs, concluding that broad releases in similar *In re Managed Care* settlement agreements barred subsequent RICO and antitrust claims. MDL 1334 D.E. 6022 (R&R on Settling Def. CIGNA's Mots. to Enforce Injunction); MDL 1334 D.E. 6023 (R&R on Settling Def. CIGNA's Mot. to Enforce Injunction). Judge Moreno adopted both of those R&Rs. MDL 1334 D.E. 6032-33. Plaintiffs appealed both Orders but this Court dismissed those appeals due to lack of appellate jurisdiction. *Klay (AMA et al.) v. All Defendants*, No. 09-16261 (11th Cir. June 16, 2010) (per curiam); *Klay (Higashi) v. All Defendants*, No. 09-16302-E (11th Cir. Apr. 21, 2010).

"Plaintiffs' ERISA and contractual claims asserted in the UCR [MDL] all pertain to WellPoint's practices regarding the fee-for-service claims and the calculation of UCRs," or "the very same practices" that were "expressly addressed in the In re Managed Care Complaints," *Id.* at 16. Judge Torres also noted that "[i]n no way does the Release immunize WellPoint from liability against new RICO, antitrust or contractual violations that arise from a brand new set of events and course of conduct than the one settled in the MDL Litigation." *Id.* at 22.

On March 8, 2011, the District Court adopted Judge Torres' R&R and ordered the plaintiffs in the UCR MDL to withdraw their claims against WellPoint within 20 days or else be found in contempt. MDL 1334 D.E. 6190.

A number of the UCR MDL plaintiffs withdrew their claims, but Appellants did not.

D. Motion to Find Appellants in Contempt and Impose Sanctions

On September 19, 2011, after Appellants and certain other plaintiffs still had not withdrawn their claims in the UCR MDL, WellPoint moved the District Court to find Appellants and the other noncompliant plaintiffs in contempt. D.E. 6264. On October 17, 2011, the UCR MDL plaintiffs filed the Third Consolidated Amended Complaint. UCR MDL D.E. 274. On January 10, 2012, the District Court granted WellPoint's motion, found the noncompliant plaintiffs in contempt, and scheduled a sanctions hearing. MDL 1334 D.E. 6303. The parties submitted extensive briefing on the question of sanctions and the propriety of the underlying finding of contempt. MDL 1334 D.E. 6313, 6316, 6318, 6327, 6328, 6329, 6331, 6334, 6335, 6336.

WellPoint sought (1) a coercive sanction against the plaintiffs and (2) a compensatory sanction for attorney's fees. The District Court held a hearing to determine the appropriate sanctions on March 16, 2012. MDL 1334 D.E. 6322, 6324. On July 25, 2012, the District Court entered a final Order of Contempt and Sanctions, in which it ordered the physician Appellants to pay $100 and the association Appellants to pay $500 for every month they continued to violate the order. MDL 1334 D.E. 6340. The court declined to rule on compensatory sanctions, but noted that it was granting the motion in part and denying it in part.

E. Present Appeal and Jurisdiction

On July 26, 2012, Appellants filed this appeal, seeking review of the July 25, 2012 Order issuing sanctions against Appellants. Appellants challenge the validity of the District Court's July 25, 2012 Order, arguing that the District Court, in its March 8, 2011 Order, erred in finding that Appellants violated the Injunction. Thus, we must presently consider both Orders. Appellant Br. at 14-15.

After the filing of the Notice of Appeal, on November 5, 2012, the UCR MDL plaintiffs filed their Fourth Consolidated Amended Complaint.[5] UCR MDL D.E.

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[5] On September 5, 2012, the UCR MDL court, the Central District of California, issued an Order granting in part and denying in part WellPoint and Ingenix's Motions to Dismiss, and dismissed the RICO and antitrust claims with prejudice. UCR MDL D.E. 365. Appellants nevertheless ask this Court to review the Southern District of Florida's ruling that the Settlement Agreement released those claims in order to preserve their Ninth Circuit appellate rights as to the Central District of California's dismissal. Appellant Br. at 28 n.9. In their Fourth Consolidated Amended Complaint, Appellants reassert causes of action under federal antitrust and conspiracy law. UCR MDL D.E. 373.

373. The UCR MDL docket is unclear on which is the operative complaint.

This Court has jurisdiction pursuant to 28 U.S.C. § 1291, which grants us "jurisdiction of appeals from all final decisions of the district courts." The District Court's July 25, 2012 Order constitutes a final order because it disposed of all issues before it. See MDL 1334 D.E. 6340; *Thomas v. Blue Cross & Blue Shield Ass'n*, 594 F.3d 814, 819 (11th Cir. 2010) ("In postjudgment proceedings, a postjudgment order is final for purposes of section 1291 if it 'finally settles the matter in litigation' by disposing of all issues raised in the motion.'" (quoting *Delaney's, Inc. v. Ill. Union Ins. Co.*, 894 F.2d 1300, 1305 (11th Cir. 1990)).

III. THE PARTIES' CONTENTIONS

A. Appellants' Contentions

Plaintiffs-Appellants argue that the District Court erred by finding them in violation of the Injunction and requiring them to dismiss their claims in the UCR MDL, and thus also erred by holding them in contempt and sanctioning them. Appellants argue that the District Court Orders constituted legal error since the claims asserted in the UCR MDL do not constitute Released Claims. Appellants first contend that a Released Claim must not only arise from the facts at issue and settled in MDL 1334, but must also have arisen prior to the Effective Date of the Settlement Agreement. *Id.* at 21. Appellants tacitly concede that the allegations in the UCR MDL relate to those of MDL 1334, but they contend that the asserted claims could not have been brought as part of MDL 1334 and, therefore, did not arise prior to the Effective Date of the Settlement Agreement. *Id.* at 13.

Appellants focus specifically on their ERISA claims, which they argue accrue only once each of the following steps is complete: (1) a provider treats a WellPoint plan member, (2) WellPoint plan members or their provider submits an application of benefits to WellPoint, (3) WellPoint fails to make appropriate payment, and (4) the member or provider exhausts available administrative remedies. *Id.* at 24-25. The UCR MDL Second Consolidated Amended Complaint alleges some instances where each of these elements took place after the Effective Date. *Id.* at 26. Appellants argue that they could not have asserted those ERISA claims prior to the Effective Date and, thus, those claims do not constitute Released Claims. *Id.*

Moreover, Appellants contend that the District Court's interpretation of the Settlement Agreement would result in an agreement that releases future claims, in contravention of public policy. *Id.* at 14. Appellants argue that Judge Moreno's interpretation would bar, in perpetuity, any physician from putting forth any claim regarding WellPoint's use of Ingenix to make benefit determinations. *Id.* at 16.

B. WellPoint's Contentions

WellPoint asks this Court to affirm the District Court's Orders because the Settlement Agreement barred the UCR MDL plaintiffs from pursuing their claims, which arose out of similar allegations made in MDL 1334. Appellee Br. at 4. Appellees argue that the Magistrate Judge correctly identified the claims at issue in the UCR MDL as Released Claims under the terms of the Settlement Agreement, and that the District Court acted within its discretion by adopting the R&R. *Id.* at 16-17.

WellPoint contends that Appellants do not dispute that their claims in the UCR MDL "aris[e] out of, or in any way relate[ ] to" the matters at issue in MDL 1334, but rather that they merely argue that their claims did not arise prior to the Effective Date. *Id.* at 27. In response, WellPoint argues that the Magistrate Judge correctly observed that Appellants' arguments "are premised on a conspiracy and course of conduct that allegedly began in 1998, years before the Effective Date." D.E. 6132 (Resp. to Objs. to R&R) at 9-10. WellPoint further argues that Appellants' attempt to read into the contract a requirement that a cause of action must have accrued prior to the Effective Date must fail because the argument lacks any basis in the contractual language. Rather, according to WellPoint the Settlement Agreement includes very broad release language, including an expansive definition of "claim" and language expressly releasing "unknown," "unsuspected," and "contingent" claims—in fact, Appellants released all claims "of whatever kind or character—"whether or not concealed or hidden." Appellee Br. at 34 (quoting Settlement Agreement § 13.5).[6]

Despite Appellants' efforts to distance their ERISA claims from their conspiracy allegations, WellPoint argues that those claims arise from the same alleged

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[6] WellPoint argues against the import of cases relied on by Appellants to show when claims accrue because those cases discuss accrual in the statute of limitations context, not in an effort to interpret contractual language. The Supreme Court recently made clear the distinction between the accrual of an ERISA cause of action and the applicable statute of limitations. *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604, 610 (2013) ("At the same time, we have recognize that statutes of limitation do not inexorably commence upon accrual.").

course of conduct that underlies all other allegations in both MDLs: that WellPoint improperly used the Ingenix database to price claims for out-of-network service. *Id.* at 45.

IV. ANALYSIS

A. Standard of Review

The propriety of the District Court's contempt order turns on whether it properly interpreted the Settlement Agreement.[7] The law is clear that "[p]rinciples governing general contract law apply to interpret settlement agreements." *In re Chira*, 567 F.3d 1307, 1311 (11th Cir. 2009) (interpreting settlement agreement under Florida law) (quoting *Resnick v. Uccello Immobilien GMBH, Inc*., 227 F.3d 1347, 1350 (11th Cir. 2000)). District Courts must construe contracts to give effect to the parties' intentions. *Accord Solymar Investments, Ltd. v. Banco Santander S.A*., 672 F.3d 981, 991 (11th Cir. 2012) (citing *Commerce Nat'l Bank v. Safeco Ins. Co*., 252 So. 2d 248, 252 (Fla. 4th DCA 1971)). This court reviews a district court's interpretation of contract provisions de novo. *Ohio Cas. Ins. Co. v. Holcim (US), Inc*., 548 F.3d 1352, 1356 (11th Cir. 2008).

This Court reviews a district court's civil contempt order for abuse of discretion. *Riccard v. Prudential Ins. Co*., 307 F.3d 1277, 1296 (11th Cir. 2002). "[W]hen employing an abuse-of-discretion standard, we must affirm unless we find that the district court has made a clear error of judgment, or has applied the wrong

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[7] The parties agreed that the Settlement Agreement "and all agreements, exhibits, and documents relating to [the] Agreement shall be construed under the laws of the State of Florida, excluding its choice of law rules." Settlement Agreement § 25.

legal standard." *United States v. Frazier*, 387 F.3d 1244, 1259 (11th Cir. 2004; *see also Klay v. United Healthgroup, Inc*., 376 F.3d 1092, 1096 (11th Cir. 2004) ("A district court abuses its discretion if it applies an incorrect legal standard, follows improper procedures in making the determination, or makes findings of fact that are clearly erroneous." (quoting *Martin v. Automobili Lamborghini Exclusive, Inc.,* 307 F.3d 1332, 1336 (11th Cir. 2002)).

A district court's contempt determination must be "supported by clear and convincing evidence." *Riccard*, 307 F.3d at 1296. If the evidence is such that a reasonable person could find a clear and convincing violation of the Injunction, this Court must affirm the contempt ruling of a district court. *Howard Johnson Co. v. Khimani*, 892 F.2d 1512, 1516 (11th Cir. 1990).

B. The All Writs Act

Federal courts have long recognized a court's power to effectuate its orders. The All Writs Act, 28 U.S.C. § 1651(a), provides that "[t]he Supreme Court and all courts established by Act of Congress may issue all writs necessary or appropriate in aid of their respective jurisdictions and agreeable to the usages and principles of law." A federal court thus retains the power "to effectuate and prevent the frustration of orders it has previously issued in its exercise of jurisdiction otherwise obtained." *United States v. New York Tel. Co*., 434 U.S. 159, 172, 98 S. Ct. 364, 372, 54 L.Ed.2d 376 (1977); see also *Henson v. Ciba–Geigy Corp*., 261 F.3d 1065, 1068 (11th Cir. 2001) ("[A] district court has the authority . . . to enjoin a party to litigation before it from prosecuting an action in contravention of a settlement agreement over which the district court has retained jurisdiction."); *Wesch v. Folsom*, 6 F.3d 1465, 1470 (11th Cir. 1993) (noting that

the All Writs Act, 28 U.S.C. § 1651, "empowers federal courts to issue injunctions to protect or effectuate their judgments").

Federal courts may invoke the authority conferred by the All Writs Act to enjoin parties from prosecuting separate litigation to protect the integrity of a judgment entered in a class action and to avoid relitigation of issues resolved by a class action. *See, e.g., United States v. New York Tel. Co.,* 434 U.S. at 172 ("This Court has repeatedly recognized the power of a federal court to issue such commands under the All Writs Act as may be necessary or appropriate to effectuate and prevent the frustration of orders it has previously issued in its exercise of jurisdiction otherwise obtained."); *Klay*, 376 F.3d at 1104 ("We have ruled, for example, that a district court may issue an injunction under the All Writs Act to prevent prosecution of a state court action that had already been settled under the terms of a federal settlement agreement."); *Wesch*, 6 F.3d at 1470 ("The district court here based its injunction on the long recognized power of courts of equity to effectuate their decrees by injunctions or writs of assistance and thereby avoid relitigation of questions once settled between the same parties."); *VMS Ltd. P'ship Sec. Litig. v. Prudential Sec. Inc.*, 103 F.3d 1317, 1324 (7th Cir. 1996), overruled on other grounds by *Envision Healthcare, Inc. v. PreferredOne Ins. Co*., 604 F.3d 983 (7th Cir. 2010) ("Other circuits have similarly approved a district court's use of the All Writs Act to prevent litigants from frustrating or circumventing its orders."); *White v. Nat'l Football League*, 41 F.3d 402, 409 (8th Cir. 1994) ("While the All Writs Act is not an independent grant of jurisdiction, the ability to facilitate the present settlement by enjoining related suits of absent class members in ancillary to

jurisdiction over the class action itself."); *In re Y & A Grp. Sec. Litig.*, 38 F.3d 380, 382-83 (8th Cir. 1994) ("The All Writs Act makes plain that each federal court is the sole arbiter of how to protect its own judgments . . . It is this concept that underlies the related rule that the court which issues an injunction is the only one with authority to enforce it."); *see also Henson*, 261 F.3d at 1068 ("[A] district court has the authority under the Act to enjoin a party to litigation from prosecuting an action in contravention of a settlement agreement over which the district court has retained jurisdiction.").

C. Civil Contempt Jurisprudence

We review "a district court's interpretation of its own orders only for an abuse of discretion," a standard that "carries over to the interpretation of injunctions." *Alley v. U.S. Dep't of Health and Human Servs.*, 590 F.3d 1195, 1201 (11th Cir. 2009).

"Great deference is due the interpretation placed on the terms of an injunctive order by the court who issued and must enforce it." *Ala. Nursing Home Ass'n v. Harris*, 617 F.2d 385, 388 (5th Cir. 1980);[8] *Alley v. U.S. Dep't of Health and Human Servs.*, 590 F.3d 1195, 1202 (11th Cir. 2009) ("The district court is in the best position to interpret its own orders." (internal quotation marks omitted)); *Cave v. Singletary*, 84 F.3d 1350, 1354 (11th Cir. 1996) ("The district court's interpretation of its own order is properly accorded deference on appeal when its interpretation is reasonable.").

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[8] In *Bonner v. City of Prichard*, 661 F.2d 1206 (11th Cir. 1981) (en banc), we adopted as binding precedent all decisions of the former Fifth Circuit handed down before October 1, 1981. *Id.* at 1209.

Notwithstanding the deference afforded to the District Court's interpretation of its own orders, the law is clear that "[i]nvalidity of the underlying order is . . . a defense to a civil contempt citation." *In re Novak*, 932 F.2d 1397, 1401 n.6 (11th Cir. 1991); see also *United States v. United Mine Workers of Am.*, 330 U.S. 258, 295, 67 S. Ct. 677, 696, 91 L. Ed. 884 (1947) ("The right to remedial relief falls with an injunction which events prove was erroneously issued."). Thus, the application of an incorrect legal standard taints the District Court's findings in support of a contempt order. *See Holton v. City of Thomasville Sch. Dist.*, 425 F.3d 1325, 1355 (11th Cir. 2005).

D. Interpretation of the Settlement Agreement

For many reasons, the district court's interpretation of its own injunction and decision to hold parties in contempt for violating that injunction should be upheld unless a district court a makes a clear error of law in contract interpretation.

The District Court is best equipped to assess the parties' intentions in entering a settlement agreement and, therefore, to construe its terms, particularly in a complicated litigation such as MDL 1334. See *Weyher/Livsey Constructors, Inc. v. Int'l Chem. Co.*, 864 F.2d 130, 131 n.1 (11th Cir. 1989) (noting that "matter[s] of interpretation" are "best left to the district court").

MDL 1334 is a highly complex multidistrict litigation, first assigned to the Southern District of Florida in April 2000. The allegations involve a wide-ranging conspiracy by many participants, affecting a large number of plaintiffs. The parties took more than five years to reach the Settlement Agreement and moved for its preliminary approval on July

11, 2005. MDL 1334 D.E. 4321. The District Court issued its Amended Order approving that Settlement Agreement on January 3, 2006, MDL 1334 D.E. 4684, after months of hearings and briefing. Judge Moreno issued his Order imposing sanctions on Appellants in July 2012, over twelve years after the case first came before the Southern District of Florida. That Order appears on the docket as entry number 6,340.

In *Thomas v. Blue Cross & Blue Shield Ass'n*, 594 F.3d 814, 817 (11th Cir. 2010), this Court considered release language similar to that of the present Settlement Agreement. There, we set forth the framework for determining whether the release language in a settlement agreement bars claims:

> Under the settlement agreement entered in the class action, the relevant inquiry for determining whether a claim is released is not whether the acts giving rise to the complaint occurred after the class action was filed or the settlement agreement was entered, but whether they occurred after the effective date of the settlement agreement.

Id. at 822. Thus, if "the acts giving rise to the complaint occurred . . . after the effective date of the settlement agreement," the agreement would not release them; whereas, if they arose prior to the effective date of the agreement, they would be barred.

In his R&R, the Magistrate Judge applied this framework and concluded that "all of the Physician Plaintiffs' claims arose 'from acts that occurred before the effective date' of the WellPoint Settlement" and were therefore barred by the "broad and sweeping" release language. MDL 1334 D.E. 6116 (R&R) at 16, 20-21.

Appellants do not contend that the Magistrate Judge applied an incorrect legal standard. Nor do they cite any legal authority to suggest that the Magistrate Judge adopted the incorrect legal framework when interpreting the Settlement Agreement. In fact, the cases that they cite in their opening brief endorse the same relevant inquiry set forth by the Magistrate Judge—that is, that the "relevant inquiry for determining whether a claim is released is . . . whether the acts giving rise to the [new] complaint . . . occurred after the effective date of the settlement agreement." Appellant Br. at 30 (quoting *Thomas v. Blue Cross & Blue Shield Ass'n*, 594 F.3d at 817 (alterations in original).[9]

Appellants have failed to show that the District Court abused its discretion in barring the Appellants from pursuing their RICO and antitrust claims in the UCR MDL and holding them in contempt when they refused to withdraw those claims. Appellants, however, have demonstrated that the District Court erred in enjoining the ERISA claims to the extent that

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[9] Appellants also rely on *Klay v. All Defs*., 309 F. App'x 294 (11th Cir. 2009) and *Madison Square Garden, L.P. v. National Hockey League*, No. 07 CV 8455(LAP), 2008 WL 4547518 (S.D.N.Y. Oct. 10, 2008). These cases, along with *Thomas*, agree upon the appropriate analysis when determining whether a release provision in a settlement agreement releases claims in a subsequent action. The District Court must determine whether the legal basis of the claim relies on events that predated the effective date of the agreement. *See Klay*, 309 F. App'x at 295 (noting magistrate judge's conclusion that plaintiffs were "forced to concede that their claims predate[d] the Effective Date of the settlement"); *Madison Square Garden, L.P.*, 2008 WL 4547518, at *6 (finding antitrust claim barred by release because it existed "at the time of the release" and "contain[ed] no allegations of post-2005 conduct").

they stem from the denial or underpayment of benefits post-dating the Effective Date, and therefore the Injunction should be vacated to the extent that it bars these claims.

A. RICO and Antitrust Allegations

With respect to the RICO and antitrust claims, Appellants' argument falls far short. In reasoning adopted by the District Court, the Magistrate Judge observed that the Appellants "d[id] not dispute that they were aware well before entering into the Settlement Agreement about WellPoint's utilization of the Ingenix Database in order to allegedly engage in their industry-wide conspiracy to underpay providers." R&R at 11. The Magistrate Judge continued: "[T]aken as a whole, the allegations listed in the Complaint clearly relate to the alleged conspiracy of WellPoint and other managed care institutions to underpay providers for their services." *Id.* at 13.[10] Magistrate Judge Torres noted, and the District Court agreed, that Plaintiffs had the option of seeking to enforce the Settlement Agreement if WellPoint had not complied with it, but stated that Appellants could not "get another bite at a very devoured apple if they are not happy with consideration they received in exchange for their broad release." *Id.* at 13.

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[10] In comparison, consider our opinion in *Doctors Health, Inc. v. Aetna*, 605 F.3d 1146 (11th Cir. 2010). There, Appellants appealed the district court's determination that their breach of contract claim had been released in a settlement agreement from an earlier class action. We vacated that determination, holding that the release did not bar Appellants' breach of contract claim where that claim "share[d] no factual basis" with the complaint in the earlier class action. *Id.* at 1151.

In adopting the R&R, the District Court properly determined that the Settlement Agreement released the Appellants' RICO and antitrust claims in the UCR MDL. First, the record fully supports the District Court's finding that Appellants' RICO and antitrust claims arose out of the claims at issue in MDL 1334. The RICO and antitrust claims in the UCR MDL echo the earlier allegations in MDL 1334—that WellPoint engaged in a scheme to underpay healthcare providers for claims through the use of the Ingenix database. The Second Consolidated Amended Complaint makes clear that the conspiracy enterprise "was formed in 1998" and that the antitrust conduct also began "at least as early as January 1, 1998." UCR MDL D.E. 113-1 (Second Consol. Am. Compl.) ¶¶ 288, 369. Second, the factual record clearly demonstrates that these claims could have been asserted at the time of the Effective Date, since all facts necessary to state a cause of action had occurred long before the Settlement Agreement took effect. The fact that Appellants seek to base the new claims on certain conduct post-dating the Effective Date does not change this conclusion. Because they merely constitute a continuation of the conspiracy alleged in MDL 1334, WellPoint's purported bad acts are best seen as new, overt acts within an ongoing conspiracy, rather than new claims in and of themselves.

Moreover, Appellants' decision to release claims stemming from the conspiracy alleged in MDL 1334 in no way interfered with their ability to obtain relief from ongoing violations of the Settlement Agreement. Through its Approval Order, the district court retained jurisdiction over "all matters relating to (a) the interpretation, administration, and consummation of the Settlement Agreement and (b) the enforcement of the injunctions described[.]" Approval

Order ¶ 27. Although Appellants were barred from asserting new claims premised on violations of the Settlement Agreement, they could have sought relief from such violations through the procedure to which they consented: namely, through a motion in the district court to enforce the Settlement Agreement and Approval Order.

These claims thus arose "on or before the effective date," "could have been asserted" against WellPoint, and "ar[o]s[e] out of, or [were] in any way related to any of the . . . facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances, or other matters referenced" in MDL 1334.[11] Settlement Agreement § 13.1(a). The RICO and antitrust claims therefore constitute Released Claims under § 13.1 of the Agreement. Because the Settlement Agreement released these claims, the District Court did not abuse its discretion by ordering Appellants to withdraw them and holding Appellants in contempt when they refused to comply with that order.

B. ERISA Allegations

The district court did, however, incorrectly interpret the Settlement Agreement and thereby abused its discretion with respect to certain of the ERISA claims. ERISA claims "could [not] have been asserted" on or before the Effective Date to the extent that they were based on denials or underpayments following the Effective Date.

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[11] Appellants argue that plaintiffs can assert continuing violations of RICO, however, the claims clearly arose before the Effective Date and could have been asserted against WellPoint at that time.

WellPoint contends that the ERISA claims "arise from the exact same alleged course of conduct that underlies the entire UCR MDL Complaint" in that the claims are based entirely on an alleged scheme that WellPoint improperly used the Ingenix database to price claims for out-of-network services. Appellee Br. at 45.

The Magistrate Judge agreed with WellPoint. The R&R states:

> Plaintiffs enjoy the broad and sweeping nature of the Settlement Agreement's release. Plaintiffs' ERISA and contractual claims asserted in the UCR [MDL] all pertain to WellPoint's practices regarding the fee-for-service claims and the calculation of the UCRs. The very same practice and WellPoint's alleged improper use of the Ingenix database were expressly addressed in the [MDL 1334] Complaints.

MDL D.E. (R&R) 6116 at 16. There is no dispute that a claim could have arisen before the Effective Date if facts forming the basis of the claim existed prior to the Effective Date. We assume, without deciding, that the District Court correctly concluded that the ERISA claims arise out of the "facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters" at issue in MDL 1334.

However, the District Court's conclusion—that "all of Physician Plaintiffs' claims arose 'from acts that occurred before the effective date' of the WellPoint Settlement and are, similarly, barred"—does not follow. *Id.* at 21. That conclusion does not complete the analysis because Appellants contend, in part, that

even if the necessary factual basis upon which Appellants could assert their ERISA claims did exist at the time of the Effective Date, the claims nevertheless could not have been asserted at that time. Put another way, if the ability to "assert" an ERISA cause of action for denial of these benefits only occurred after the Effective Date of the Settlement Agreement, then § 13.1(a) would not bar such a claim.

Our resolution of this issue hinges in large part on at what point an ERISA claim can be asserted.[12] A similar issue arose in *Paris v. Profit Sharing Plan for Emp. of Howard B. Wolf*, 637 F.2d 357, 361 (5th Cir. Feb. 17, 1981). In *Paris*, we considered whether we had jurisdiction—there, whether the claim arose under federal jurisdiction—to review a district court's determination that appellants were not entitled to certain benefits under ERISA. The jurisdictional question turned on whether the claim arose before the date on which ERISA took effect: January 1, 1975. *Id.* at 359. If the claim arose on the date of the claimant's termination, it would predate the Effective Date of ERISA. If it arose upon the denial of benefits, it would post-date the Effective Date, and thus arise under federal law. We held that we did have jurisdiction, observing that "for purposes of ERISA a cause of action does not accrue until an application [for benefits] is denied." *Id.* at 361. This holding was

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[12] Dictionaries offer a broad definition of the word "assert" and provide no guidance as to whether "assert" in the Settlement Agreement requires the filing of a lawsuit. See, e.g., Black's Law Dictionary 124 (8th ed. 2004) ("1. To state positively. 2. To invoke or enforce a legal right."); Oxford English Dictionary Online, http://english.oxforddictionaries.com (last visited Mar. 18, 2014) (defining assert as to "state a fact or belief confidently and forcefully").

followed by this *Court in Gulf Life Ins. Co. v. Arnold*, 809 F.2d 1520, 1525 (11th Cir. 1987). Accordingly, an ERISA lawsuit cannot be filed in federal court until a claim is denied.

In keeping with this conclusion, Appellants' ERISA claims based on the denial or underpayment of benefits following the Effective Date cannot meet the "could have been asserted" prong of § 13.1 of the Settlement Agreement because, absent a denial or underpayment on or before the Effective Date, such claims would not have accrued. Appellants set forth a number of allegations that meet these criteria. For instance, the Second Consolidated Amended Complaint alleges that, following the Effective Date, Dr. Schwendig provided emergency medical services to patients participating in a plan that WellPoint administered. UCR MDL D.E. 113-1 (Second Consol. Am. Compl.) ¶¶ 224. Dr. Schwendig was allegedly underpaid, appealed the purported underpayments, and was unable to recoup the amount owed to him. *Id.* at ¶ 228. Likewise, in November and December of 2007, Dr. Kavali purportedly provided medical services, was underpaid for those services, and was given no apparent mechanism for appealing the underpayment. *Id.* at ¶¶ 254-56, 259. Because ERISA claims stemming from the denial or underpayment of benefits following the Effective Date "could [not] have been asserted" on the Effective Date, the District Court erred in enjoining the Appellants from pursuing such claims.

WellPoint argues that another section of the Settlement Agreement, titled Covenant Not to Sue, supports its interpretation and the District Court's Contempt Order. We disagree. Section 13.2(a) states

that the releasing parties will not participate in litigation "based upon or related to any Released Claim." In effect, WellPoint argues that any underpayment must be related to this settlement simply by virtue of being an underpayment. But the inclusion of an Effective Date into the Settlement Agreement clearly contrasts the idea of barring all claims against WellPoint in perpetuity. The Covenant Not to Sue section does not apply to claims that could not have been asserted prior to the Effective Date and, therefore, does not bar such claims.

We note briefly that, even though § 13.5 broadens the scope of the release, it does not go so far as to release claims where the full factual basis required to legally state a cause of action, such that the cause of action "could have been asserted," did not exist as of the Effective Date. In § 13.5, Appellants agreed to "fully, finally and forever" release "any known or unknown, suspected or unsuspected, contingent or non contingent claim with respect to the subject matter of the provisions of § 13, whether or not concealed or hidden, without regard to the discovery or existence of such different or additional facts." Settlement Agreement § 13.5. This section broadly releases any claim that could have been brought, at the time of the Effective Date, based on the existence of facts—whether they be known or unknown—as of the Effective Date. The language of this section does not, however, go so far as to release claims based on facts occurring after the Effective Date.[13]

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[13] Undoubtedly, certain facts existed that could have given rise to some ERISA claims, even if not the ones presently at issue, and Appellants had knowledge of those facts. For example, the Second Consolidated Amended Complaint alleges that WellPoint underpaid for benefits for many years prior to the Effective Date

Furthermore, the Settlement Agreement does release post-Effective Date claims in certain narrow instances. In § 13.1(b), which addresses claims against BCBSA, the release language makes clear that the parties agreed to "forever abandon and discharge any and all Claims that exist now or that might arise in the future" where such claims "are based on conduct by any of the Released Parties that occurred on or before the Effective Date and are, or could have been asserted by any Releasing Party . . . ." Settlement Agreement § 13.1(b). If the parties had intended the scope of § 13.1(a) to mirror that of 13.1(b), which expressly releases claims that could arise after the Effective Date—although based on conduct that existed prior to the effective date—the parties would have used such language in § 13.1(a). Accordingly, at least some of Appellants' ERISA claims "could [not] have been asserted" on the Effective Date. The Settlement Agreement does not release them, and the Injunction must be vacated as to such claims.

We note that Judge Martin dissents from our opinion, in part, based on her conclusion that the Settlement Agreement does not bar the RICO and antitrust claims. We agree with Judge Martin that the Settlement Agreement "did not protect WellPoint for any misconduct for all time." The crux of our disagreement, however, is that Judge Martin believes that the allegations in the UCR MDL indicate "new, wrongful conduct" whereas we view the conduct as

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of the Settlement Agreement. Denial of proper payment for those benefits may have constituted an ERISA claim that could have been asserted prior to the Effective Date. Appellants should have explicitly excluded such ERISA claims in the release, but did not do so. This, however, has no bearing on ERISA claims based on underpayment for procedures performed after the Effective Date.

being a continuation of the same conduct raised in MDL 1334.

The cases cited by Judge Martin do not persuade us otherwise. For example, Judge Martin distinguishes *Madison Square Garden, L.P. v. National Hockey League*, 2008 WL 4547518. There, the court observed that the plaintiff's allegations were not based on conduct that post-dated the release, but were instead based on a continuation of pre-existing policies. *Id.* at *6. The court thus had "little trouble" concluding that the antitrust claims existed at the time of the release and that the parties intended the release to bar those claims. *Id.* We view the UCR MDL allegations similarly, and conclude that the claims based on those allegations "could have been asserted," and were in fact asserted, prior to the Effective Date.

We once again note that Appellants were not without recourse if WellPoint acted in violation of the Settlement Agreement after the Effective Date. Rather, they could have filed a motion in the district court to enforce the Settlement Agreement and the corresponding Approval Order. Their failure to do so does not warrant a departure from the parties' intentions to bar claims that arose out of the conduct at issue in MDL 1334 and that could have been asserted as of the Effective Date.

In sum, because Appellants' ERISA claims that are premised on the denial or underpayment of benefits subsequent to the Effective Date do not fall within the "could have been asserted" prong of the Settlement Agreement, the Settlement Agreement does not release such claims. Thus, we vacate the District Court's judgment barring Appellants' ERISA claims to the extent that they arise out of post-Effective Date underpayments or denials of benefits.

V. SANCTIONS

A district court has "broad discretion in fashioning civil contempt sanctions," *Howard Johnson Co. v. Khimani*, 892 F.2d 1512, 1519 (11th Cir. 1990), and this court "review[s] the district court's assessment of contempt sanctions for an abuse of discretion," *McGregor v. Chierico*, 206 F.3d 1378, 1388 (11th Cir. 2000). Appellants do not challenge the method by which the District Court assessed sanctions, but rather limit their challenge to the validity of the underlying Order barring Appellants from proceeding with their claims. On remand, the District Court will be tasked with determining which of Appellants' ERISA claims are based on the denial or underpayment of benefits following the Settlement Agreement's Effective Date. The District Court will also need to reconsider its assessment of sanctions in light of this opinion. Thus, we will vacate the sanctions and remand to the District Court.

VI. CONCLUSION

For the foregoing reasons, the judgment of the District Court is affirmed in part, vacated in part, and remanded. We affirm the Injunction as to Appellants' RICO and antitrust claims and as to ERISA claims based on the denial or underpayment of benefits on or before the Settlement Agreement's Effective Date, but vacate the Injunction as to ERISA claims based on the denial or underpayment of benefits following the Settlement Agreement's Effective Date. On remand, the District Court will need to determine which of Appellants' ERISA claims fall on the permissible side of the line, and reconsider the assessment of sanctions. AFFIRMED IN PART; VACATED IN PART; REMANDED.

MARTIN, Circuit Judge, concurring in part and dissenting in part:

I agree with my colleagues that, based on WellPoint's actions after the Effective Date of the Settlement Agreement in the earlier class action regarding WellPoint's reimbursement of claims, the District Court abused its discretion in concluding that certain ERISA claims in the later-filed cases were Released Claims.[1] But based on the language of that Settlement Agreement, I would reach this same result for the RICO and antitrust claims the Physicians seek to bring here as well. Like the ERISA claims, the RICO and antitrust claims also depend on WellPoint's actions taken after the Effective Date. Therefore, the ruling I seek that the ERISA, RICO, and antitrust claims based on WellPoint's actions taken after the Effective Date of the Settlement Agreement were not released by that Agreement—would treat all of these claims the same. In contrast, the Majority's Opinion reaches different results for various claims made based on identical post-Effective Date actions taken by WellPoint and vacates the injunction only as to certain ERISA claims. I would lift the Injunction as to the

[1] I will use the terms the Majority did, including UCR MDL (referring to the lawsuit filed in 2009 challenging the post-Settlement Agreement's usual, customary, and reasonable rates of reimbursement, which is the subject of this appeal), MDL 1334 (referring to the case number of the earlier litigation originally filed in 2000, assigned as a Multi-District Litigation case to the District Court in the Southern District of Florida, and settled in 2005), and BCBSA (Blue Cross Blue Shield of America). Also, when I use the term Physicians, I refer collectively to the doctors and their professional associations that are the Appellants in this case.

RICO and antitrust claims as well, so I dissent from the Majority Opinion in that respect.

I. BACKGROUND

In 2005, WellPoint agreed to change a number of its business practices in order to settle MDL 1334. Among the changes WellPoint agreed to was to change the way it had determined usual, customary, and reasonable rates. Specifically, the Settlement Agreement stated that WellPoint "agrees that, to the extent it uses Physician charge data to determine the usual, reasonable and customary amount to be paid for services performed by Non-Participating Physicians, it will not use any internal claims database that" systematically underprices the claims.

For their part, the Physicians agreed that as of the Effective Date of the agreement they were giving up certain claims. The Settlement Agreement defined the Released Claims as:

> any and all causes of action, judgments, liens, indebtedness, costs, damages, obligations, attorneys' fees, losses, claims, liabilities and demands of whatever kind or character (each a "Claim"), arising on or before the Effective Date, that are, were or could have been asserted against any of the Released Parties by reason of, arising out of, or in any way related to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referenced in the Actions, whether any such Claim was or could have been asserted by any Releasing Party on its own behalf or on behalf of other Persons,

> or to the business practices that are the subject of § 7.

Settlement Agreement § 13.1(a). As the Majority recognizes, "the inclusion of an Effective Date into the Settlement Agreement clearly contrasts the idea of barring all claims against WellPoint in perpetuity." Maj. Op. at 31.

After preliminary approval of the settlement by the District Court, a notice of the settlement was mailed to potential class members. The notice began: "IF YOU ARE A PHYSICIAN WHO PROVIDED COVERED SERVICES TO ANY INDIVIDUAL ENROLLED IN OR COVERED BY CERTAIN HEALTH CARE PLANS AT ANY TIME BETWEEN AUGUST 4, 1990 AND JULY 15, 2005 . . . PLEASE READ THIS NOTICE CAREFULLY." The part of the notice that told the class members about the claims which would be released against WellPoint described them as those "arising on or before the date that the Court's order approving the settlement becomes final, that are, were or could have been asserted." The next sentence added that "claims that exist now or that might arise in the future" are waived against BCBSA. The notice highlighted that at an upcoming hearing, the District Court "will consider whether to enter orders that would prevent members of the Class and certain other persons, including the Defendants in the Actions other than WellPoint, from asserting certain claims against WellPoint in the future."

The District Court approved the Settlement Agreement for MDL 1344 in an Amended Order filed in January 2006. That Order permanently enjoined the Physicians who had not opted out of the Settlement Agreement from participating in lawsuits "arising out of or relating in any way to the Released

Claims." Generally tracking the language in the class notice, the amended order approving the settlement noted that claims "that exist now or that might arise in the future against BCBSA" were released, while against WellPoint claims were released "that are, were or could have been asserted against any of the Released Parties by reason of, arising out of, or in any way related to" the facts at issue. The District Court retained jurisdiction on "all matters relating to (a) the interpretation, administration, and consummation of the Settlement Agreement and (b) the enforcement of the injunctions described."

Then in 2009 came the UCR MDL lawsuit alleging antitrust, RICO, ERISA, and state law violations by WellPoint and others in connection with a conspiracy of failing to pay the UCR rates for out-of-network services. The Second Consolidated Amended Complaint in the UCR MDL alleged that "Ingenix serves as a conduit for the conspiracy and is a hidden profit engine of the health insurance business." That Complaint includes allegations, for example, that after the Effective Date of the Settlement Agreement for the MDL 1344 case, WellPoint provided false and misleading certifications to Ingenix, and that Ingenix, knowing that certain answers from WellPoint were false, "continued to accept the data and overlook the falsehoods, nevertheless." Fundamentally, the question presented by this appeal is whether the claims raised by these plaintiffs in the UCR MDL are barred because they are Released Claims under the MDL 1334 Settlement Agreement.

II. DISCUSSION

There are two related ways to analyze whether the claims advanced in this lawsuit were released in the earlier one. The first is to examine the language used

in the Settlement Agreement and class notice. The second is to apply this Court's precedent to the facts of this case. Both analyses lead to the conclusion that the UCR MDL claims were not released.

A. TEXT OF THE SETTLEMENT AGREEMENT AND CLASS NOTICE

I begin with the language of the Settlement Agreement, particularly the definition of Released Claims. It is not in dispute that if parties to a settlement clearly and unambiguously agree to do so, "[f]uture damages may be released if such is the intent of the parties." *W.J. Perryman & Co. v. Penn Mut. Fire Ins. Co.*, 324 F.2d 791, 793 (5th Cir. 1963).[2] However, the language of a settlement agreement determines whether that is so. "Litigation or settlement will not automatically bar a later suit for a second, identical breach." *Klein v. John Hancock Mut. Life Ins. Co.*, 683 F.2d 358, 360 (11th Cir. 1982). There are two ways in which the definition of Released Claims here indicates the intent to limit the release and not include future damages. They are the definition's time limit of "arising on or before the Effective Date," and the statement that the claims released "are, were or could have been asserted."

Because the term "arising" is not defined in the Settlement Agreement, it is necessary to look to the common understanding of the term. For a long time, courts have understood that an action does not arise until a plaintiff has a legal right to sue on it. *See, e.g., St. Louis & S.F.R. Co. v. Spiller*, 274 U.S. 304, 313, 47

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[2] In *Bonner v. City of Prichard*, 661 F.2d 1206 (11th Cir. 1981) (en banc), we adopted as binding precedent all decisions of the former Fifth Circuit handed down before October 1, 1981. *Id.* at 1209.

S. Ct. 635, 638 (1927) (finding "that the term 'arise' was used in the decree as the equivalent of 'accrue'"); *Fed. Reserve Bank v. Atlanta Trust Co*., 91 F.2d 283, 287 (5th Cir. 1937) ("This cause of action did not, it could not, arise until plaintiff had paid the moneys out, and was in a position to demand reimbursement."); *see also Levy v. Ohl*, 477 F.3d 988, 992 (8th Cir. 2007) (stating that "plaintiff's right to sue arises . . . when the plaintiff could first maintain his cause of action successfully" (quotation omitted)).

Based on this understanding of the word arising, and because the Settlement Agreement defined Released Claims as those "arising on or before the Effective Date," the Physicians released only those claims they could have sued for as of the Effective Date. In contrast, the only claims asserted in the UCR MDL were those that required additional acts to take place after the Effective Date. Critically, the Physicians allege that WellPoint committed new acts after the Effective Date, which caused them to be underpaid for certain services.

The import of the definition of Released Claims in the Settlement Agreement is buttressed by its use of the phrase "are, were or could have been asserted." "Are" asserted claims were those asserted at the time of the Settlement Agreement—clearly the claims in the UCR MDL are not among those. "Were" asserted claims would be those that had already been asserted. Again, the UCR MDL claims had not. The question remaining, then, is whether the UCR MDL claims "could have been" brought at the time the parties entered into the Settlement Agreement. Following this analysis, the Majority acknowledges and recognizes that certain claims in the UCR MDL *could not have been brought* but for the new actions WellPoint took

after the Effective Date. Maj. Op. 30–31. I agree. However, the Majority does not extend the logic behind its recognition that the ERISA claims could not have been brought prior to the Effective Date of the Settlement of the MDL 1344 case to the remainder of claims brought by the Physicians in the UCR MDL. To the contrary, the Majority finds that the remaining claims were released by the Settlement Agreement.

WellPoint argues that the Physicians "do not suggest . . . WellPoint began doing something different or new that it had not been doing before." But this argument ignores that WellPoint agreed to quit doing what it had done before. The Physicians entered into the Settlement Agreement, which called for payments by WellPoint and WellPoint's agreement to change the way it made reimbursements so as to avoid future problems. Nothing in the Settlement Agreement suggests that the Physicians gave up their right to take action in the future if WellPoint engaged in new, wrongful conduct that resulted in underpayment for services not yet rendered. So while the Physicians never dispute that WellPoint had underpaid them in the past, they do allege new acts resulting in fresh underpayments. *Cf. Manning v. City of Auburn*, 953 F.2d 1355, 1360 (11th Cir. 1992) ("[W]e do not believe that the res judicata preclusion of claims that 'could have been brought' in earlier litigation includes claims which arise after the original pleading is filed in the earlier litigation.").

This plain reading of the Settlement Agreement is in keeping with the notice to potential class members. Certainly it is the language of the Settlement Agreement that controls, but the notice underscores that the UCR MDL claims were not released in the MDL 1334. First, the notice, in all capital letters, tells

physicians who provided services "between August 4, 1990 and July 15, 2005" to read the notice carefully. As a result, physicians providing services after July 15, 2005 are not given any notice that they are impacted by the settlement. It is only those doctors who provided services between the delineated dates that were clearly informed of the release. Physicians who had not yet provided the relevant services, but might do so in the future, would understandably believe this notice had no relevance to them.

Second, the notice states that class members are giving up "all claims that exist now or that might arise in the future" against BCBSA. But the language the parties chose to describe the claims that were released against WellPoint is strikingly different. For WellPoint, the notice says that class members are giving up claims arising on or before the Effective Date. It is true that the details of the settlement, including the treatment of possible future claims, was to be the subject of a hearing before the District Court. Again however, the notice gave no indication that the Settlement Agreement was intended to release future claims against WellPoint by class members for services not yet rendered.

WellPoint argues that if the Settlement Agreement is interpreted to allow for future claims, "companies would not be able to settle class action lawsuits because they could never be assured of 'buying peace' no matter how much they paid." Quite to the contrary, the Settlement Agreement did buy peace for WellPoint for all of its conduct prior to the Effective Date. It just did not protect WellPoint for any misconduct for all time. WellPoint remains "on the hook" for any new bad acts it commits after the Effective Date. And it is only new actions, taking place after the Settlement

Agreement, which are at issue in the UCR MDL. *See Lawlor v. Nat'l Screen Serv. Corp.*, 349 U.S. 322, 329, 75 S. Ct. 865, 869 (1955) ("Acceptance of the respondents' novel contention would in effect confer on them a partial immunity from civil liability for future violations.").

WellPoint argues that another section of the Settlement Agreement, titled "Covenant Not to Sue," supports their interpretation. Section 13.2(a) states that the releasing parties will not participate in litigation "based upon or related to any Released Claim." While the use of "related to" in § 13.2(a) suggests a broader covenant not to sue than what is in the definition of Released Claims, when read alongside the other Settlement Agreement provisions it is clear the parties intended a cutoff point. WellPoint argues, in effect, that any underpayment must be related to this settlement, simply by virtue of being an underpayment. But the setting of an Effective Date within the Settlement Agreement conflicts with the idea of barring all claims against WellPoint in perpetuity. New actions taken by WellPoint after the Effective Date of the Settlement Agreement, and resulting in underpayments, are not covered by the Covenant Not To Sue. Those claims—ERISA or otherwise—are therefore not released.

Counsel for WellPoint seemed to acknowledge this point at oral argument. He said that if WellPoint began doing something new after the Effective Date, it would be actionable under the Settlement Agreement:

> So let's say we stopped using Ingenix in 2008 and we began using a brand new database that we hadn't used before. Then I think the Plaintiffs could come along and say, "Well,

> look, we're complaining about something new that you weren't doing before."[3]

But this is a distinction without a meaningful difference. The Settlement Agreement does not mention Ingenix. The gravamen of the Physicians' concern was with being underpaid—by whatever mechanism. The Settlement Agreement was intended to compensate the Physicians for underpayments in the past and change WellPoint's business practices to avoid underpayments in the future. And the Majority acknowledges that WellPoint engaged in "new, overt acts." Maj. Op. at 26. However, the Majority characterizes those acts as being a part of "an ongoing conspiracy." The plain language of the Settlement Agreement provides that claims predicated upon future acts taken by WellPoint to underpay physicians are not released.

B. APPLICATION OF CASE LAW TO FACTS

A familiar canon of construction helps clarify that the claims here were not released. The word "future" does not appear in the definition of Released Claims in § 13.1(a) of the Settlement Agreement. And the parties were certainly aware of their ability to negotiate away future claims. That is evidenced by the fact that the parties referred to future claims in § 13.1(b), where the Settlement Agreement discusses claims against BCBSA. To my mind, this distinction demonstrates the parties' choice not to address future claims as to WellPoint. *See In re Celotex Corp*., 487 F.3d 1320, 1334 (11th Cir. 2007) ("[W]hen certain matters are mentioned in a contract, other similar matters not mentioned were intended to be excluded." (quotation

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[3] Oral Argument at 27:52–28:11, Oct. 9, 2013.

omitted)); *see also* Maj. Op. at 32–33 ("If the parties had intended the scope of § 13.1(a) to mirror that of 13.1(b), which expressly releases claims that could arise after the Effective Date—although based on conduct that existed prior to the effective date—the parties would have used such language in § 13.1(a).")

WellPoint argues that "federal class action settlements routinely include releases waiving future claims." This is certainly true. However, the cases WellPoint points to in support of this proposition are readily distinguishable, at least because the Settlement Agreement it relies upon does not refer to future claims against WellPoint. For example, WellPoint cites to *McClendon v. Georgia Department of Community Health*, 261 F.3d 1252 (11th Cir. 2001). The McClendon litigation arose out of a tobacco settlement agreement negotiated by 46 states and a number of tobacco companies. The *McClendon* plaintiffs were Medicaid recipients who wanted proceeds of the settlement beyond what Georgia paid on medical assistance, but they had not participated in the negotiations of that settlement agreement. The defendants moved to dismiss. In addition to being factually inapposite and arising in a very different procedural posture, then, the language of the release in *McClendon* refers explicitly to "future conduct" and "future Claims." *Id.* at 1254. Considering that language, this Court observed that "[a]s the quoted provisions indicate, by entering into the settlement agreement Georgia released its past and future claims." *Id.* at 1255. The *McClendon* release clearly reflected the intent of the parties as to future claims, while the agreement before us does not. For many reasons, *McClendon*'s guidance for this case is limited.

WellPoint also points to cases addressing antitrust violations based on conduct that originated at a prior time, arguing that courts "have found that releases do bar antitrust claims when they are based on a continuation of the released conduct." Again—this is certainly true. However, the utility of the cases relied upon by WellPoint to help it here is belied by the facts of those decisions. For example, WellPoint claims the case *Madison Square Garden, L.P. v. National Hockey League*, 2008 WL 4547518 (S.D.N.Y. Oct. 10, 2008), is similar to this case. Instead it is quite different. Madison Square Garden had signed an agreement that "forever releases and discharges" the National Hockey League from any claims related to policies in effect at the time the agreement was executed in 2005. *Id.* at *5. Notwithstanding this language, Madison Square Garden sued based on "no allegations of post-2005 conduct apart from (1) the enforcement of pre-existing policies and (2) the 2006 extension of the licensing agreement that had been in place since 1994, which reaffirmed each Member Club's assignment of the right to 'use or license its team's trademarks' to the League." *Id.* at *6. Given the gap between what claims Madison Square Garden released and what claims the subsequently brought, the District Court "ha[d] little trouble" dismissing certain claims. *Id.* at *7. Quite distinctive from *Madison Square Garden*, this case involves new post-release conduct. Thus, the holding in *Madison Square Garden* is of little assistance here.

WellPoint also relies on *Klay v. All Defendants*, 309 F. App'x 294 (11th Cir. 2009). In *Klay*, the plaintiffs were "forced to concede that their claims predate the Effective Date of the settlement." *Id.* at 295 (quoting MDL 1334 Dkt. 5838 (MDL 1334 R&R) at 18). Indeed, a review of the Report & Recommendation in that case makes the distinction between *Klay* and this case even

more clear. In *Klay*, "Plaintiffs suggest that it is irrelevant whether their claims existed prior to the settlement, so long as they were subjectively unaware of the existence of their claims." (MDL 1334 R&R at 18 (emphasis added)). There is no such concession or suggestion here. Thus, *Klay* is of little relevance to this case. The same is true of *Thomas v. Blue Cross & Blue Shield Ass'n*, 594 F.3d 814 (11th Cir. 2010), another case relied upon by WellPoint and cited by the Majority. *See Id.* at 822 ("Kolbusz's claims of tortious interference and defamation arise from acts that occurred before the effective date, which is the only date the district court should have considered.").

WellPoint is correct that this Court and others have encouraged the pretrial settlement of class action lawsuits. *See, e.g., In re U.S. Oil & Gas Litig.*, 967 F.2d 489, 493 (11th Cir. 1992). But I am not aware that this Court has ever encouraged protection for future wrongdoing, particularly where parties have not expressly addressed it in their settlement agreement. The Settlement Agreement here did not immunize WellPoint for future underpayments to doctors. For these reasons, I would vacate the Injunction not just for the ERISA claims, but for the RICO and antitrust claims as well.

APPENDIX B

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

{Filed 8/15/2010}

Case No. 00-MD-1334-MORENO

THIS DOCUMENT RELATES ONLY TO
PROVIDER TRACK CASES

IN RE MANAGED CARE LITIGATION

CHARLES B. SHANE, M.D., *et al*.,
Plaintiffs,

vs.

HUMANA INC., *et al.*
Defendants

REPORT AND RECOMMENDATION ON
SETTLING DEFENDANT WELLPOINT'S MOTION
TO ENFORCE INJUNCTION

This matter is before the Court on Settling Defendant WellPoint, Inc.'s Motion to Enforce Injunction Against Physician Plaintiffs[1] in *In re WellPoint, Inc. Out-of-Network "UCR" Rates Litigation* [D.E. 6053]. The Court has considered the motion, the

[1] The "Physician Plaintiffs" include Drs. Stephen D. Henry, James G. Schwendig, Hooman M. Melamed, and Carmen Kavali. They also include the California Medical Association, the Medical Association of Georgia, the Connecticut State Medical Society, the North Carolina Medical Society, and the American Medical Association ("AMA").

response, the reply, the sur-reply and the pertinent portions of the record. For the reasons discussed below, this Court recommends that WellPoint's Motion be Granted.

I. BACKGROUND

On April 17, 2000, the Judicial Panel on Multidistrict Litigation ("MDL Panel") ordered the creation of *In re Managed Care Litigation*, Case No. 1:00-MDL-1334. This MDL case concerned, among other things, reimbursement for health care services by managed care companies and was divided into two tracks: one involving broad claims by health care providers and the other involving broad claims by subscribers to health care plans. The provider track was a class action brought on behalf of all providers who submitted claims to health care companies, including WellPoint and its affiliates and subsidiaries, for the provision of medical services. This class included both physicians and non-physician health care providers, as well as providers with contracts with WellPoint and those without contracts.

The providers alleged that health insurance companies engaged in a conspiracy to inflate profits by systematically denying, delaying, and diminishing payments due to them. The HMOs allegedly effected this scheme through the manipulation of computerized billing programs. Throughout the pendency of this complex class-action litigation, settlements have been reached between numerous providers and several of the insurers. On July 11, 2005, WellPoint reached one such settlement agreement with the

physician providers ("WellPoint Settlement Agreement") [D.E. 4321], which the Court approved on December 22, 2005.[2] [D.E. 4671].

The Final Order enjoined class members from filing new lawsuits in which "Released Claims" are asserted against "Released Parties:"

> The Releasing Parties are permanently enjoined from: (i) filing, commencing, prosecuting, intervening in, participating in (as class members or otherwise) or receiving any benefits from any lawsuit, arbitration, administrative or regulatory proceeding or order in any jurisdiction based on any or all Released Claims against one or more Released Parties; (ii) instituting, organizing class members in, joining with class members in, amending a pleading in or soliciting the participation of class members in, any action or arbitration, including but not limited to a purported class action, in any jurisdiction against one or more Released Parties based on, involving, or incorporating, directly or indirectly, any or all Released Claims, and (iii) filing, commencing, prosecuting, intervening in, participating in (as class members or otherwise) or receiving any benefits from any lawsuit, arbitration, administrative or regulatory proceeding or order in any jurisdiction based on an allegation that an action

[2] On December 31, 2005, the Court issued an Amended Order Approving Settlement Among WellPoint, Inc. and Physicians, Physician Groups and Physician Organization, Certifying Class and Directing Entry of Final Judgment [D.E. 4684]. This Amended Order is collectively referred to herein with the December 22, 2005 Order as the "Final Approval Order."

> taken by Company, which is in compliance with the provisions of the Settlement Agreement, violates any legal rights of any member of the Class.

See Final Approval Order ¶ 9.[3]

In early 2009, a collection of physicians, non-physician health care providers, WellPoint subscribers, and medical associations filed multiple class action lawsuits against Wellpoint. In August 2009, these cases were consolidated as a federal multi-district litigation in the Central District of California before the Honorable Phillip S. Gutierrez ("UCR Litigation").[4]

Following the consolidation, Plaintiffs filed their First Consolidated Amended Complaint ("Complaint") that asserts claims against various defendants, including WellPoint, on behalf many classes and

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[3] The Eleventh Circuit has affirmed our previous orders enforcing such settlement agreements as this one entered in the MDL. *See*, *e.g.*, *Thomas v. Blue Cross and Blue Shield Ass'n*, No. 08-15395, 2009 WL 1483522 (11th Cir. May 28, 2009); *Klay v. All Defendants*, No. 08-12906, 2009 WL 179617 (11th Cir. Jan. 27, 2009).

[4] The ten lawsuits consolidated in the UCR Litigation were: (1) *Roberts v. UnitedHealth Group, Inc.*, *et al.*, No. 09-cv-1886 (C.D. Cal.); (2) *Am. Med. Ass'n*, *et al. v. WellPoint, Inc.*, No. 09-2039 (C.D. Cal.); (3) *J.B.W., etc. v. UnitedHealth Group, Inc.*, *et al.*, No. 09-cv-2488 (C.D. Cal.); (4) *Higashi v. Blue Cross of California*, No. 09-cv-4223 (C.D. Cal.); (5) *N. Peninsula Surgical Ctr., L.P. v. WellPoint, Inc.*, *et al.*, No. 09-cv-4510 (C.D. Cal.); (6) *Pariser v. WellPoint, Inc.*, No. 09-cv-4783 (C.D. Cal.); (7) *Unmacht v. WellPoint, Inc.*, No. 09-cv-5863 (C.D. Cal.); (8) *Samsell*, *et al. v. WellPoint, Inc.*, et al., No. 09-cv-6079 (C.D. Cal.); (9) *Am. Podiatric Med. Ass'n*, *et al. v. WellPoint, Inc.*, No. 09-cv-6725 (C.D. Cal.); and (10) *Bernard*, *et al. v. WellPoint, Inc.*, No. 09-cv-6726 (C.D. Cal.).

subclasses of physicians. Specifically, the Physician Plaintiffs assert fifteen causes of action: (i) violation of Section 1 of the Sherman Antitrust Act 15 U.S.C. § 1; (ii) various violations of the Employee Retirement Income Security Act ("ERISA") 29 U.S.C. § 1002, 1104 & 1132; (iii) violations of the Racketeer Influenced and Corrupt Organizations Act ("RICO") 18 U.S.C. § 1962; (iv) breach of contract claims; (v) breach of implied covenant of good faith and fair dealing; (vi) violations of California's unfair and deceptive trade practices statutes; (vii) violations of New York's General Business Law § 349; (viii) violations of California's Cartwright Act; and (ix) civil conspiracy. *See* Complaint ¶¶ 359-483 [D.E. 6053-1].

All causes of action in the California UCR Complaint stem from WellPoint's alleged failure to reimburse the non-participating providers the contractually obligated "usual, customary and reasonable" ("UCR") amount for the services rendered by them. *See* Complaint ¶¶ 10-12. According to the Complaint, WellPoint allegedly utilized database called Ingenix in order to calculate the inaccurate and improper UCR amounts due to plaintiffs. The allegations further state that WellPoint used and continues to use the Ingenix database as the primary source of data upon which it bases its UCR determinations, even though WellPoint knows that it cannot and should not be used for that purpose. *See* Complaint ¶ 69. The Complaint also alleges that WellPoint committed, and conspired to commit with its direct competitors, numerous violations of the Sherman Antitrust Act, 15 U.S.C. § 1 *et seq*. These antitrust violations allegedly stem from WellPoint's price-fixing with regard to paying reasonable and customary rates for non-party transactions and from

WellPoint's manipulation of the Data Market in order to create below-market UCRs. *See* Complaint ¶ 79.

In light of the Final Approval Order, and the undisputed fact that all named individual Provider Plaintiffs in the UCR Litigation did not opt out of the class,[5] WellPoint moves this Court to enforce the settlement against these Provider Plaintiffs and compel the withdrawal of all of their claims in the UCR Litigation. WellPoint argues that all of the claims, including the RICO and antitrust causes of action, arose prior to the date of the Final Approval Order and are, therefore, barred by the settlement agreement.

Provider Plaintiffs responded to the pending motion opposing the enforcement of the judgment. Plaintiffs contend that their claims are not Released Claims because they arose after the WellPoint Settlement Agreement became final. Namely, Plaintiffs argue that: (i) because the Complaint alleges a series of new injuries occurring after the effective date of the Final Approval Order, the alleged antitrust, RICO, and ERISA violations, as well as, contractual claims arose only after 2006 and were not released by the settlement and (ii) WellPoint's invocation of general release to prospectively bar a private antitrust action arising from post-release violations is against public policy. According to Plaintiffs, each and every time an individual physician is harmed by WellPoint's alleged under-reimbursement subsequent to the effective date

[5] Although the American Medical Association is not a Signatory Medical Society, the Complaint states that it is asserting claims on behalf of its physician members who are Settlement Class members. *See* Complaint ¶ 35.

of the settlement agreement, a new cause of action arose that is not subject to the release.

II. ANALYSIS

The language of the Court's Final Approval Order clearly prohibits Class members from initiating lawsuits against Released Parties for any claims released by the Settlement. This Court, therefore, must grant Settling Defendant's motion if three conditions exist: (i) the Provider Plaintiffs are class members; (ii) WellPoint is a Released Party under the Settlement; and (iii) the claims at issue in the UCR Litigation are Released Claims.

A. Provider Plaintiffs are Class Members

The Final Approval Order permanently certified a settlement class composed of the following members:

> Any and all Physicians, Physicians Groups and Physicians Organizations who provided Covered Services to any Plan Member or any other individual enrolled in or covered by a plan offered or administered by any Person named as a defendant in the Complaints or by any of their respective current or former Subsidiaries or Affiliates, in each case from August 4, 1990 through the Preliminary Approval Date.

See Final Approval Order ¶ 2. It is undisputed that none of the Plaintiffs opted out of the settlement, and are therefore class members bound by the terms of the Final Approval Order. Furthermore, with the exception of the AMA, neither of the named Provider

Plaintiffs, both individual and associational, disputes that it is subject to the settlement agreement.[6]

B. Defendant is a Released Party

It is also undisputed that the Final Approval Order includes WellPoint as a Released Party.

C. All of Provider Plaintiffs' Claims are Released Claims

A litigation release of claims is a contract, thus it is construed according to the normal rules of contract interpretation. *See*, *e.g.*, *V & M Erectors, Inc. v. Middlesex Corp.*, 867 So. 2d 1252, 1253-54 (Fla. 4th DCA 2004). When interpreting a contract under Florida law,[7] the Court is guided first by the language of the documents itself. *See Dows v. Nike, Inc.*, 846 So. 2d 595, 601 (Fla. 4th DCA 2003). Where the terms of a contract are clear and unambiguous, the Court may not consider parol evidence but instead must determine the intent of the parties from the four corners of the document. *Id*. Furthermore, when the terms are unambiguous, the language itself is the best evidence of the parties' intent and its plain meaning controls. *Acceleration Nat'l Serv. Corp. v. Brickell Fin. Servs. Motor Club, Inc.*, 541 So. 2d 738, 739 (Fla. 3d DCA 1989).

The language of the Court's Final Approval Order and the Settlement Agreement clearly prohibits Class

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[6] With regard to AMA's claims, WellPoint's motion only seeks to enforce the injunction against AMA's claims brought on behalf its members who were Released Parties under the Settlement Agreement. The motion does not, however, challenge AMA's claims brought on its own behalf that allege direct injury to AMA.

[7] The Settlement Agreement contains a Florida Choice-of-Law provision. *See* Settlement Agreement at 85 [D.E. 4321].

members from initiating claims against "Released Parties" which arise out of "or in any way [are] related to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referred to in the Actions." *See* Final Approval Order ¶ 5. The Settlement Agreement defines "Released Claims" as:

> any and all causes of action, judgments, liens, indebtedness, costs, damages, obligations, attorneys' fees, losses, claims, liabilities and demands of whatever kind or character, arising on or before the Effective Date, that are, were or could have been asserted against any of the Released Parties by reason of, arising out of, or *in any way related to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referenced in the Actions*, whether any such Claim was or could have been asserted by any Releasing Party on its own behalf or on behalf of other Persons, or to the business practices that are the subject of § 7. This includes, without limitation and as to Released Parties only, any aspect of any Fee for Service Claim submitted by any Class Member to Company [WellPoint], and any claims of any Class Member *related to or based upon a Capitation agreement between Company [WellPoint] and any Class Member or other person or entity, or the delay, nonpayment or amount of any Capitation payments by Company [WellPoint], and any allegations that other defendants in the Actions and/or Company [WellPoint] have conspired with, aided and abetted, or*

> *otherwise acted in concert with other managed care organizations, other heath insurance companies, Delegated entities and/or other third parties with regard to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referred to in the Actions*, or with regard to Company's liability for any other demands for payment submitted by any Class member to such other managed care organizations, health insurance companies, Delegated Entities and/or third parties.

See WellPoint Settlement Agreement § 13.1(a) (emphasis added). Because the terms of the Settlement Agreement prohibit the Provider Plaintiffs from filing these "Released Claims," we need to determine if the claims are "in any way related to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters" that were subject of the prior litigation.

As Defendant correctly points out, the Complaint asserts RICO and antitrust claims based on a purported conspiracy in which WellPoint allegedly agreed with other health insurers to use a third-party database to determine the UCRs. As in the MDL, Providers Plaintiffs allege in their Complaint that the conspiracy enabled WellPoint and its purported Co-Conspirators to systematically under-compensate non-participating providers for medical services they rendered. Namely, Plaintiffs claim that WellPoint and its Co-Conspirators rely on a database maintained by a third party, Ingenix, Inc., which Plaintiffs allege does not accurately or properly determine the UCRs:

105. In October 1998, the members of HIAA [Health Insurance Association of America] (including WellPoint) *agreed* to sell the PHCS to Ingenix for an undisclosed amount. This was part of a plan by Ingenix and its parent company, UnitedHealth, to acquire a dominant position in the market for the provision of data services used to calculate UCR that included over 50 acquisitions.

108. Ingenix, upon purchasing the PHCS, also entered into a Confidentiality Agreement mandating that it shield from disclosure the identity of entities (*i.e.*, Defendants and Insurer Conspirators in this action) that had submitted or would submit information for use in the database.

109. By and through the creation and eventual domination of the Data Market by Ingenix, Defendants and the Conspirators *conspired and agreed* to create, expand, continue, promote and use the Ingenix Database to control and set False UCRs among and between purported horizontal competitors in the health insurance market (including WellPoint and the Insurer Conspirators) with the ultimate aim of reimbursing ONS [Outside Network Services] below market levels.

133. WellPoint and the Insurers Conspirators' scheme to manipulate UCRs for the purpose of under-reimbursing for ONS is predicated, in part, on keeping the Ingenix Database, and its inherent flaws, a complete secret from the subscribers and providers. As a result, Defendants and its Insurer

> Conspirators actively conceal the true UCRs, knowing the success of the scheme will be jeopardized if true UCRs are known to the healthcare-purchasing public.
>
> 279. The WellPoint-Ingenix Enterprise was formed in 1988, at the time of the sale of the PHCS database by HIAA to Ingenix.
>
> 283. The WellPoint-Ingenix Enterprise was at all relevant times a continuing unit involving WellPoint, UnitedHealth, and Ingenix functioning with a common purpose of reducing the price paid for ONS, and increasing the profits of Enterprise participants and the Insurer Conspirators. The Enterprise described above was utilized to create a mechanism or vehicle by which Defendants could reduce payments to Plaintiffs and the Classes for ONS through the use of flawed and invalid data that could not be challenged effectively. In particular, as described herein, the Enterprise was used to create and administer what appeared to be an appropriate and unassailable database which reported actual charge data; the Ingenix Database was designed to appear valid as a basis for UCR when, in fact, it is and was, invalid.

See Complaint ¶¶ 105, 108, 109, 133, 279 and 283.

Careful analysis of the allegations raised in the UCR Litigation Complaint shows that the RICO and antitrust claims clearly fall within the scope of Released Claims under the Final Approval Order because they all relate to WellPoint's conspiracy to systematically under-compensate the

non-participating providers. Furthermore, all of Plaintiffs' RICO and antitrust claims are based on allegations that WellPoint "conspired with, aided and abetted, or otherwise acted in concert with other managed care organizations, other heath insurance companies, and/or other third parties" to underpay reimbursements due to non-participating providers.

Plaintiffs essentially do not dispute that their claims are "related to" or "based on" the "facts, acts, events, transactions, occurrences" that were subject of the MDL. Plaintiffs, however, contend that the RICO and antitrust claims did not arise before the Final Approval Order was entered by the Court. According to Plaintiffs, because the Complaint alleges a continuing antitrust conspiracy, a separate cause of action arises each time the plaintiff is injured. As Plaintiffs' claims are only for injuries that occurred after the Final Approval Date, those claims did not arise until after that Date, and no injunction is warranted. Likewise, under the "separate accrual" doctrine, a separate RICO claim accrues separately for each new and independent injury to his business or property caused by violation of RICO. In turn, because Plaintiffs did not suffer compensable injury from WellPoint's commission of the predicate acts alleged in the Complaint before the Final Approval Date, these RICO claims did not accrue until after the Final Approval Date. Therefore, these claims were not released by the settlement agreement in the MDL Litigation.

We, however, disagree and find these arguments to be totally misplaced as they ignore the material terms of the broad release language found in the MDL Settlement Agreement.

Plaintiffs do not dispute that they were aware well before entering into the Settlement Agreement about WellPoint's utilization of the Ingenix Database in order to allegedly engage in their industry-wide conspiracy to underpay providers. Instead of opting out of the Class and deciding to pursue their claims individually, the Provider Plaintiffs decided to agree to broadly release their claims. In exchange, Provider Plaintiffs received substantial payments from WellPoint and changes to its business practices on a prospective basis. These measures were expected to cost WellPoint over two hundred fifty million dollars. *See* WellPoint Settlement Agreement § 7.31.

Indeed, Section 7 of the Settlement Agreement expressly addresses WellPoint's business practice regarding the determination of the UCR rates. It states:

> Company [WellPoint] agrees that, to the extent it uses Physician charge data to determine the *usual, reasonable and customary* amount to be paid for services performed by Non-Participating Physicians, it will not use any internal claims database that (i) systematically under-reports the number of claims paid for procedures in the geographic area used by Company [WellPoint] to determine such amount; (ii) eliminates or excludes the highest charges for paid claims for any procedures in the geographic area used by Company [WellPoint] to determine such fees, provided, however, that such charges may be excluded if Company [WellPoint] excludes an equivalent number or percentage of the lowest charges for such procedures, or reasonably determines that

> any such charges are the result of erroneous data; (iii) includes charges for procedures performed in a geographic area other than the one used by Company [WellPoint] to determine such amount, provided, however, that such charges may be considered where Company [WellPoint] determines there is an insufficient number of charges in the relevant geographic area to reasonably determine a usual, reasonable and customary amount; (iv) calculates the usual, reasonable and customary amount based upon fees paid under a discounted fee schedule rather than billed charges; and (v) lacks quality controls sufficient to reasonably test the validity of the data included in the database.

See WellPoint Settlement Agreement § 7.14(d) (emphasis added). Clearly, part of the settlement consideration on behalf of WellPoint included changes in its practices regarding the determination of the UCRs.

Moreover, the Settlement Agreement also contemplates and addresses Non-Participating Physicians' appeals of WellPoint's UCR rates:

> At least until the Termination Date, if a Non-Participating Physician initiates a dispute using Company's [WellPoint's] internal dispute resolution procedures over how Company [WellPoint] has determined the usual, reasonable and customary amount for a given health care service or supply, and, consequently, over how Company [WellPoint] has computed the amount payable for that health care service or supply, Company [WellPoint] shall disclose to the

> Non-Participating Physician initiating the dispute the general methodology, including the percentile of included charge data on which the maximum allowable amount is based, and source of data used by Company [WellPoint] to determine the usual, reasonable and customary amount for that service or supply.

See WellPoint Settlement Agreement § 7.14(c).

If it is Plaintiffs' position that WellPoint has not complied with any of the terms of the Settlement Agreement, Plaintiffs have at their disposal the agreement's very detailed and specific enforcement mechanism. *See generally* WellPoint Settlement Agreement § 12. This mechanism provides that any Class Member, such as any of the Provider Plaintiffs in this case, "who contends that Company [WellPoint] has materially failed to perform specific obligations under § 7 of this Agreement, and that such Class Member is adversely affected by Company's failure to comply with such specific obligations under § 7" may file a complaint with the Compliance Dispute Facilitator. *See* WellPoint Settlement Agreement § 12.2(a). Plaintiffs may not, however, get another bite at a very devoured apple if they are not happy with consideration they received in exchange for their broad release.

The fact that the Complaint narrows the Provider Plaintiffs Class to only those that rendered services to WellPoint's members after the September 29, 2006 effective date of the Settlement Agreement does not alter our conclusion. Rather, taken as a whole, the allegations listed in the Complaint clearly relate to the alleged conspiracy of WellPoint and other managed care institutions to underpay providers for their

services. Therefore, as we previously stated, claims based on such allegations fall within the scope of the Released Claims under the Settlement Agreement.

A recent antitrust case arising in a different factual context illustrates the point. In *Madison Square Garden, L.P. v. National Hockey League*, No. 07-CV-8455(LAP), 2008 WL 4547518 (S.D.N.Y. Oct. 10, 2008), the court barred antitrust claims that plaintiff argued arose from post-Release conduct. In that case, the owner of the New York Rangers professional hockey club claimed that the National Hockey League had become an illegal cartel that prevented members clubs from competing for sponsors and fans. The court dismissed a large portion of plaintiff's case against the league because it found the claims to be barred by a 2005 consent agreement in which the company promised not to sue the NHL or related entities for antitrust violations. The Release in that case provided that MSG "forever releases and discharges" the league "from any and all claims . . . upon any legal or equitable theory" which "exist as of the date of execution . . . relating to, or arising from, any hockey operations or any NHL activity, including without limitation, the performance, presentation or exploitation of any hockey game . . . ." *Id*. at *6. The court found that although the MSG allegations characterized its claims as being based on post-Release conduct, the Complaint itself contained no allegations of post-2005 conduct apart from (1) the enforcement of pre-existing policies and (2) the 2006 extension of the licensing agreement that had been in place since 1994. *Id*. The court reasoned that "because this very antitrust 'claim' 'exist[ed]' at the time of the release, and because the only allegations in the Complaint demonstrate[d] that the League continued its enforcement of pre-existing policies," it had "little trouble concluding that the

Release evidence[d] that the 'parties had in mind a general settlement of all accounts up to that time.'" *Id*.

Indeed, based on this very reasoning, in November 2009, we issued two Report and Recommendations in which we concluded that the RICO and antitrust claims were barred under the broad release of a similar *In re Managed Care* settlement agreement. *See* Report and Recommendation on Settling Defendant CIGNA's Motions to Enforce Injunctions (AMA, Dr. Shiring & Dr. Mullins), *In re Managed Care Litig*., 00-MD-1334 (S.D. Fla. Nov. 5, 2009) [D.E. 6022] and Report and Recommendation on Settling Defendant CIGNA's Motion to Enforce Injunction (Dr. Higashi), In re Managed Care Litig., 00-MD-1334 (S.D. Fla. Nov. 5, 2009) [D.E. 6023]. Both R&Rs were adopted by Judge Moreno. [D.E. 6032 & D.E. 6033].

Subsequently, Plaintiffs appealed both Orders. The Eleventh Circuit, however, dismissed both appeals due to a lack of appellate jurisdiction. In doing so, the court of appeals stated that, aside from not being appealable as "final orders" pursuant to 28 U.S.C. § 1291, both orders were also "not appealable under 28 U.S.C. § 1292(a)(1) because the court did not so blatantly misinterpret the settlement injunctions as to constitute a modification of the injunctions." *Klay (AMA et al.) v. All Defendants*, No. 09-16261 (11th Cir. June 16, 2010) (per curiam) (Barkett, Hull, and Martin, Circuit Judges); *Klay (Higashi) v. All Defendants*, No. 09-16302-E (11th Cir. Apr. 21, 2010) (by the Court) (Tjoflat, Barkett, and Wilson, Circuit Judges); *cf. Doctors Health, Inc. v. Aetna*, 605 F.3d 1146, 1149 n.1 (11th Cir. 2010) (asserting appellate jurisdiction pursuant to 28 U.S.C. § 1292(a)(1) over a district court's injunctive order barring plaintiff from pursuing its contractual claim in the bankruptcy court

because "[b]y its own terms, the order grant[ed] a new injunction against Doctors Health. And, even if the order is considered one clarifying the injunction issued by the district court . . ., it is a modification of that existing injunction.") (per curiam) (Tjoflat, Cox, Circuit Judges, and Korman, District Judge).

Next, Plaintiffs argue their ERISA and contractual claims are not barred because these claims, unlike RICO and antitrust claims, are not conspiracy-based. According to Plaintiffs, following the Effective Date of the Settlement Agreement, every time an individual physician was underpaid due to WellPoint's improper UCR calculation a new cause of action arose that was not subject to the MDL settlement. Once again, however, Plaintiffs ignore the broad and sweeping nature of the Settlement Agreement's release. Plaintiffs' ERISA and contractual claims asserted in the UCR Litigation all pertain to WellPoint's practices regarding the fee-for-service claims and the calculation of the UCRs. The very same practices and WellPoint's alleged improper use of the Ingenix database were expressly addressed in the *In re Managed Care* Complaints:

> 120. During the past ten years the conspiracy was conducted through and implemented by:
>
> . . .
>
> (b) the development and utilization of automated and integrated claims processing and other systems such as those generated by McKesson HBOC, Ingenex [sic], and FACTS Services, Inc., and the configuration and use of such systems to similarly deny, diminish and delay payments to physicians.

127. Based upon Plaintiffs' current knowledge, the following persons constitute a union or group of individuals associated in fact that Plaintiffs refer to as the "Managed Care Enterprise" ("MCE"): (1) Defendants; (2) other health insurace companies not named as defendants herein, including Health Care Service Corporation and the Regence Group; (3) Milliam & Robertson and InterQual, third party entities which promulgate purported patient care guidelines; (4) HBOC McKesson, Ingenex [sic], Facts Services and other third party entities which develop claims processing systems or components; (5) Protocare, Inc. and other third party entities Defendants hire to review and wrongfully deny claims; (6) American Association of Health Plans and the Health Insurance Association of America, Defendants' trade association; (7) MedUnite, an entity created by Defendants and their trade association to facilitate claims processing; and (8) the Coalition for Affordable Quality Healthcare.

130. In order to successfully retain monies owed physicians in the manner set forth above, Defendants need a system that allows them to manipulate and control reimbursements to physicians and conceal the manner in which that is done. The MCE provides Defendants with that system and ability, and their control of participation in it is necessary for the successful operation of their scheme. The Defendants control and operate the MCE as follows:

. . .

> (c) By engaging and paying HBOC McKesson, Ingenex [sic] and Facts Services to develop automatic systems for editing and manipulating the claims information contained in the HCFA/CMS 1500 form.

See Providers Pls. 2d Amend. Consol. Class Action Compl. ¶¶ 120(b), 127, and 130(c) [D.E. 1607]. It is evident that Plaintiffs were well aware of WellPoint's practices when they entered into the Settlement Agreement in 2005. As previously noted, *changes to WellPoint's UCR and fee-for-service calculations were part and parcel of the settlement's consideration*. In other words, as indicated by the broad release language of the Settlement Agreement, Plaintiffs have released all of their claims based on WellPoint's alleged improper UCR calculations in exchange for detailed changes in WellPoint's business calculations outlined in Section 7. Agreement to such an extremely broad release using broadly inclusive language is clearly deliberate, and typical of class actions releases. *See*, *e.g*., *Wal-Mart Stores, Inc. v. Ivsa U.S.A. Inc*., 396 F.3d 96, 106 (2d Cir. 2005).

Equally unpersuasive is Plaintiffs' reliance on the recent decision of *Doctors Health, Inc. v. Aetna*, 605 F.3d 1146 (11th Cir. 2010), which was briefly discussed earlier in this Report and Recommendation. In that case, Doctors Health, Inc., an HMO plan manager, entered into a three-year contract with NYLCare, a subsidiary of Aetna, to manage its Medicare HMO plan in Maryland, Virginia, and the District of Columbia. *Id*. at 1147. Shortly thereafter, NYLCare decided that it would discontinue the Medicare HMO plan in Doctors Health's geographic region and informed Doctors Health that, as of

January 1, 1999, there would be no Medicare HMO plan for it to manage. *Id*.

In November 1998, Doctors Health filed a Petition for Relief under Chapter 11 of the United States Bankruptcy Code. *Id*. NYLCare submitted a proof of claim in the bankruptcy case which Doctors Health refused to pay. *Id*. Instead, the trustee filed an adversary action against NYLCare, alleging that NYLCare had breached its Medicare HMO management contract with Doctors Health and had caused Doctors Health damages in excess of NYLCare's claim in the bankruptcy case. *Id*.

In May 2003, while the bankruptcy case was still pending, Aetna (along with its subsidiary NYLCare) entered into a settlement with the *Shane* provider plaintiff class in *In re Managed Care Litigation*, Case No. 1:00-MDL-1334, the same MDL that is the source of the WellPoint's motion currently before us. *Id*. at 1148. The language of Aetna's Settlement Agreement was almost identical to the one at issue here as it released the Defendant from all claims "'arising on or before the Preliminary Approval Date, that are, were or could have been asserted against any of the Released Parties based on or arising from the factual allegations of the Complaint.'" *Id*.

In April 2005, the bankruptcy court issued its ruling in the adversary action awarding Doctors Health $21.3 million in damages. *Id*. On June 20, 2008, Aetna filed a Motion to Show Cause in this Court seeking an order enforcing the release in the Agreement as a bar to the bankruptcy court's judgment. *Id*.; *see also* Aetna's Mot. for Contempt and Supp. Mem. for an Order Requiring Doctors Health and its Attorneys to Show Cause [D.E. 5877]. Having concluded that the claim that Doctors Health had pursued against

NYLCare in the bankruptcy proceeding was a released claim, we granted Aetna's motion. *See* Order Enjoining Doctors Health [D.E. 5960].

The Eleventh Circuit, however, vacated the injunction after finding that "[t]he claim pursued by Doctors Health in the adversary action share[d] no factual basis with the *Shane* complaint." *Doctors Health, Inc*., 605 F.3d at 1151. The court also pointed out that "[w]hile *Shane* alleged that the managed-care companies underpaid providers of medical services, the breach of contract claim resolved in the adversary action hinged on Doctors Health's allegation that NYLCare breached its Medicare HMO management agreement with Doctors Health by failing to renew its Medicare agreements with the government and then prematurely terminating the Medicare HMO management agreement it had with Doctors Health." *Id*.

Our Circuit also emphasized the "[t]he release language is clear; it concerns only claims that could have been asserted 'based on or arising from the factual allegations of the [*Shane*] Complaint.'" *Id*. at 1152. Thus, the court concluded that "[t]he only reasonable reading of this clause is that the scope of claims released is limited to those claims that could have been asserted based on arising out of the factual allegations of the [Second Amended Consolidated Class Action Complaint in] *Shane*." *Id*. Consistent with this language, we conclude here that the crux of Provider Plaintiffs' allegations in the UCR Litigation is "based on" and "arise" out of the allegations listed in the *Shane* Complaint that is subject of the Settlement Agreement. Hence, *Doctors Health* fully supports our decision.

Significantly, in support of their argument, Provider Plaintiffs rely on numerous cases that concern the *res judicata* effect of an earlier judgment, rather than the *res judicata* effect of a settlement agreement. This distinction, however, is significant. Unlike the doctrine of *res judicata* in situations involving a previously litigated case, the *res judicata* effect of a settlement agreement and a judgment entered pursuant to a settlement agreement "should not be determined by the claims specified in the original complaint, but instead by the terms of the Settlement Agreement, as interpreted according to traditional principles of contract law." *Norfolk S. Corp. v. Chevron U.S.A., Inc.*, 371 F.3d 1285, 1289 (11th Cir. 2004). Here, the WellPoint Settlement Agreement expressly releases any and all claims that are "in any way related to . . . matters referenced [*In re Managed Care*] Actions," as well as any allegations that WellPoint "conspired with . . . other health insurance companies . . . with regard to any of the . . . matters referred to in the [*In re Managed Care*] Actions." *See* Final Approval Order ¶ 5. Because the Provider Plaintiffs' claims fall squarely within this unambiguous release language, they are enjoined.

Moreover, another recent decision by the our Circuit also supports our broadly preclusive interpretation of the WellPoint Settlement. In *Health Care Serv. Corp. v. Kolbusz*, 594 F.3d 814 (11th Cir. 2010), the Eleventh Circuit considered almost identical release language in a settlement agreement that resolved claims against a number of WellPoint's former co-defendants in the *Love v. Blue Cross and Blue Shield Ass'n* litigation. The court held that the "broad language" in the release encompassed the plaintiff's claims even though those precise claims had not been asserted in Love. The court reasoned:

> It is irrelevant that [the plaintiff's] claims depend on a different legal theory than the claims asserted in the class action or require [the plaintiff] to prove matters in addition to or different from the claims asserted in the class action.

Id. at 822. The court further explained:

> Under the settlement agreement entered in the class action, the relevant inquiry for determining whether a claim is released is not whether the acts giving rise to the complaint occurred after the class action was filed or the settlement agreement was entered, but whether they occurred after the effective date of the settlement agreement.

Id. Finding that the plaintiff's claims in *Kolbusz* arose "from acts that occurred before the effective," the Eleventh Circuit held that the plaintiff's claims were barred by the *Love* Settlement Agreement and that the district court had abused its discretion in denying Health Care Service Corporation's motion to enforce the settlement agreement with respect to those claims. *Id*. Similarly here, all of the Physician Plaintiffs' claims arose "from acts that occurred before the effective date" of the Wellpoint Settlement and are, similarly, barred.

Lastly, Plaintiffs contend that WellPoint seeks to use a general release to bar prospectively a private antitrust action arising from subsequent antitrust violations. On its face, however, the Release does not attempt to release claims for future violations; it expressly discharges only the claims that Plaintiffs may have against WellPoint "or could have been asserted by or on behalf of any or all Class Members"

against WellPoint "which arise prior to Final Approval" of the Settlement Agreement. In other words, the Release only applies to claims that relate to the course of conduct that originated before the date of Final Approval by the Court of the Settlement Agreement. In no way does the Release immunize WellPoint from liability against new RICO, antitrust or contractual violations that arise from a brand new set of events and course of conduct than the one settled in the MDL Litigation. The Release in the present case is different, for example, from the release in *Lawlor v. Nat'l Chrysler-Plymouth, Inc*., 349 U.S. 322 (1955), where the Supreme Court refused to give a previous settlement agreement *res judicata* effect when it would have forever extinguished the plaintiffs' future antitrust claims for *disparate types of anticompetitive conduct* that were not contemplated by the parties' settlement in the earlier antitrust litigation. *Id*. at 324-28; *see also Mktg. Assistance Plan, Inc. v. Associated Milk Producers, Inc*., 338 F. Supp. 1019, 1021-23 (S.D. Tex. 1972) (release could "not bar the assertion . . . of any post-release causes of actions" challenging "renewed monopolistic activities by the defendants" but also noting that "[n]o one would reasonably expect the consequences of pre-release conduct to cease as of the day of the release, and such damages must certainly have been contemplated by the parties.").

The problem that Provider Plaintiffs have in this case is that the claims at issue being prosecuted in the UCR Litigation are based on conspiratorial conduct, practices and "chain of events" that took place long before the execution and approval of this Settlement Agreement. A different result must thus follow here. As Judge Preska points out in her *National Hockey League* decision, considerable caselaw stands for the

proposition that public policy considerations differ when the only "prospective" application of the release in question is the continued adherence to a pre-release restraint on trade. *See also MCM Partners, Inc. v. Andrews-Bartlett & Associates, Inc*., 161 F.3d 443, 448 (7th Cir. 1998) (taking a functional approach to the question of enforceability, the court found that the conduct "clearly based" on pre-release conduct and thus enforced the release, while acknowledging that "new, post-release agreement" in restraint of trade may be actionable, but mere "continued adherence" to an alleged pre-released agreement" in restraint of trade could not give rise to a viable claim); *Hunter Douglas, Inc. v. Comfortex Corp*., No. 98-CV-0479, U.S. Dist. LEXIS 10906, at *19-21 (N.D.N.Y. Mar. 11, 1999) (release barred a claim challenging ongoing practices that had "not been altered materially since the parties executed [a release]"); *Record Club of Am., Inc. v. United Artists Records, Inc*., 611 F. Supp. 211, 217 n.8 (S.D.N.Y. 1985) (enforcing a release of an antitrust claim because "all of the harm alleged *flows from and is related to the terms of conditions* [of the release]" and was merely the "continuing effect" of pre-release conduct) (emphasis added).

Furthermore, public policy strongly favors the pretrial settlement of class action lawsuits. MDL complex class action litigation, like the *In re Managed Care Litig*., "can occupy a court's docket for years on end, depleting the resources of the parties and the taxpayers while rendering meaningful relief increasingly elusive." *In re U.S. Oil & Gas Litig*., 967 F.2d 489, 493 (11th Cir. 1992). "The Southern District of Florida has made it clear that public policy strongly favors the enforcement of settlement agreement in all types of litigation." *Baratta v. Homeland Housewares, LLC*, No. 05- cv-0187, 2007 WL 2668585, at *2-3 (S.D.

Fla. June 14, 2007) (citing *Sea-Land Serv., Inc. v. Sellan*, 64 F. Supp. 2d 1255, 1259 (S.D. Fla. 1999)). Accordingly, any "consideration[] of a settlement agreement must commence with an understanding that compromise of disputed claims is favored by the Court and will be enforced if at all possible." *Id*. (citing *Reed By & Reed Through Reed v. United States*, 717 F. Supp. 1511, 1515 (S.D. Fla. 1988); *Cia Anon Venezolana de Navegacion v. Harris*, 374 F.2d 33, 35 (5th Cir. 1967)).

Therefore, we conclude that, because Provider Plaintiffs' claims asserted in the UCR Litigation are related to claims settled by the Settlement Agreement that arose prior to the entry of this Court's Final Approval Order, they are Released Claims and Plaintiffs should be enjoined from prosecuting them in the California District Court.

III. CONCLUSION

Based on the foregoing, it is hereby RECOMMENDED that:

1. WellPoint's Motion to Enforce Injunction Against Physician Plaintiffs [D.E. 6053] should be GRANTED.

2. WellPoint's Motion to Enforce Injunction Against the American Medical Association [6053] from asserting claims on behalf of its physician members who are Settlement Class members should be GRANTED.

4. Plaintiffs Drs. Stephen D. Henry, James G. Schwendig, Hooman M. Melamed, Carmen Kavali, California Medical Association, Medical Association of Georgia, Connecticut State Medical Society, North Carolina Medical Society, and American Medical Association, should have twenty (20) days from the

date of the Court's non-final Order to withdraw all their claims against Settling Defendant WellPoint asserted in *In re WellPoint, Inc. Out-of Network "UCR" Rates Litigation*, Master File No. MDL 09-2074, except as to those claims excepted herein. If the claims are not withdrawn and/or dismissed, the Court should then Order that Plaintiffs be deemed to be in contempt of court, at which point a hearing should be scheduled to determine the appropriate remedy before entry of a final order of contempt.

Pursuant to Local Magistrate Rule 4(b), the parties have fourteen (14) days from the date of this Report and Recommendation to serve and file written objections, if any, with the Honorable Federico A. Moreno, United States District Judge. Failure to timely file objections shall bar the parties from a *de novo* determination by the District Judge of an issue covered in the report and bar the parties from attacking on appeal the factual findings contained herein. *R.T.C. v. Hallmark Builders, Inc*., 996 F.2d 1144, 1149 (11th Cir. 1993); *LoConte v. Dugger*, 847 F.2d 745 (11th Cir. 1988); *Nettles v. Wainwright*, 677 F.2d 404, 410 (5th Cir. Unit B 1982) (en banc); 28 U.S.C. § 636(b)(1).

DONE AND ORDERED in Chambers at Miami, Florida, this 15th day of August, 2010.

/s/ Edwin G. Torres
EDWIN G. TORRES
United States Magistrate Judge

APPENDIX C

UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF FLORIDA

Miami Division

[Filed 3/8/2011]

Case Number: 00-01334-MD-MORENO

IN RE MANAGED CARE LITIGATION

CHARLES B. SHANE, M.D., *et al*.,

Plaintiffs,

v.

HUMANA INC., *et al.,*

Defendants.

ORDER ADOPTING MAGISTRATE JUDGE'S REPORT AND RECOMMENDATION AND GRANTING MOTION TO ENFORCE INJUNCTION

THE MATTER was referred to the Honorable Edwin G. Torres, United States Magistrate Judge for a Report and Recommendation on Settling Defendant Wellpoint, Inc.'s Motion to Enforce Injunction Against Physician Plaintiffs (D.E. No. 6053). The Magistrate Judge filed a Report and Recommendation (D.E. No. 6116) on August 15, 2010. The Court has reviewed the entire file and record. The Court has made a *de novo* review of the issues that the objections to the Magistrate Judge's Report and Recommendation present, and being otherwise fully advised in the premises, it is

ADJUDGED that United States Magistrate Judge Edwin G. Torres's Report and Recommendation (D.E.

No. 6116) on August 15, 2010 is AFFIRMED and ADOPTED. Accordingly, it is

ADJUDGED that:

(1) Wellpoint's Motion to Enforce Injunction Against Physician Plaintiffs [D.E. No. 6053] is GRANTED.

(2) Wellpoint's Motion to Enforce Injunction Against the American Medical Association [D.E. No. 6053] from asserting claims on behalf of its physician members who are Settlement Class members is GRANTED.

(3) Plaintiffs Drs. Stephen D. Henry, James G. Schwendig, Hooman M. Melamed, Carmen Kavali, California Medical Association, Medical Association of Georgia, Connecticut State Medical Society, North Carolina Medical Society, and American Medical Association, have twenty (20) days from the date of the Court's non-final Order to withdraw all their claims against Settling Defendant Wellpoint asserted in *In re Wellpoint, Inc. Out-of-Network "UCR" Rates Litigation*, Master File No. MDL 09-2074, except as those claims excepted herein. If the claims are not withdrawn and/or dismissed, the Court will Order that Plaintiffs be deemed to be in contempt of the court, at which point a hearing will be scheduled to determine the appropriate remedy before entry of a final order of contempt. DONE AND ORDERED in Chambers at Miami, Florida, the 8th day of March, 2011.

/s/ Federico A. Moreno
FEDERICO A. MORENO
Chief United States District Judge

Copies provided to:

United States Magistrate Judge Edwin G. Torres
Counsel of Record

APPENDIX D

UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF FLORIDA
Miami Division

[Filed 1/11/2012]

Case Number: 00-1334-MD-MORENO

IN RE MANAGED CARE LITIGATION

CHARLES B. SHANE, M.D., *et al*.,
Plaintiffs,

vs.

HUMANA INC., *et al*.,
Defendants.

ORDER GRANTING WELLPOINT'S MOTION FOR CONTEMPT AND ORDER SETTING HEARING

THIS CAUSE came before the Court upon Wellpoint Inc.'s Motion for Contempt (D.E. No. 6264), filed on September 19, 2011.

THE COURT has considered the motion, the response, the reply, and the pertinent portions of the record, and being otherwise fully advised in the premises, it is

ADJUDGED that the motion is GRANTED. On March 8, 2011, the Court ordered the Physician Plaintiffs Drs. Stephen D. Henry, James G. Schwendig, Hooman M. Melamed, Carmen Kavali, California Medical Association, Medical Association of

Georgia, Connecticut State Medical Society, North Carolina Medical Society, and American Medical Association to withdraw all of their claims against Settling Defendant Wellpoint, Inc. in *In re Wellpoint, Inc. Out-of-Network "UCR" Rates Litigation*, Master File No. MDL 09-2084. Because those claims were only withdrawn or dismissed by Plaintiffs Dr. Hooman M. Melamed and American Medical Association, the Court finds the remaining Plaintiffs Drs. Stephen D. Henry, James G. Schwendig, Carmen Kavali, California Medical Association, Medical Association of Georgia, Connecticut State Medical Society, and North Carolina Medical Society, in contempt of the court. It is further

ADJUDGED that a sanctions hearing to determine the appropriate remedy before the entry of a final order of contempt shall take place before the undersigned, United States District Judge Federico A. Moreno, at the United States Courthouse, Wilkie D. Ferguson Jr. Building, Courtroom 13-3, 400 North Miami Avenue, Miami, Florida 33128, on Friday, March 16, 2012 at 9:30 A.M.

DONE AND ORDERED in Chambers at Miami, Florida, this 10th day of January, 2012.

/s/ Federico A. Moreno
FEDERICO A. MORENO
CHIEF UNITED STATES DISTRICT JUDGE

Copies provided to:

Counsel of Record

APPENDIX E

UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF FLORIDA
Miami Division

[Filed 7/25/2012]

MDL No. 1334
Master File No. 00-1334-MD-MORENO

IN RE: MANAGED CARE LITIGATION

THIS DOCUMENT RELATES TO
PROVIDER TRACK CASES

ORDER OF CONTEMPT AND SANCTIONS

THIS CAUSE came before the Court upon Parties' Sanctions Briefing (D.E. Nos. 6264, 6283, 6286, 6313, 6316, 6317, 6327, 6328, 6329, 6331, 6333, 6334, 6335, 6336, 6338, and 6339). The Court previously held a hearing on the issue of contempt and sanctions on March 16, 2012. At that time, the Court required parties to submit briefing regarding the sanctions to be imposed.

THE COURT has considered the oral argument, briefing, and the pertinent portions of the record, and is otherwise fully advised in the premises.

On March 8, 2011, the Court ordered the Physician Plaintiffs Drs. Stephen D. Henry, James G. Schwendig, Hooman M. Melamed, Carmen Kavali, California Medical Association, Medical Association of Georgia, Connecticut State Medical Society, North

Carolina Medical Society, and American Medical Association to withdraw all of their claims against Settling Defendant Wellpoint, Inc. in *In re Wellpoint, Inc. Out-of-Network "UCR" Rates Litigation*, Master File No. MDL 09-2084 within twenty (20) days. Because those claims were only withdrawn or dismissed by Plaintiffs Dr. Hooman M. Melamed, American Medical Association, and North Carolina Medical Society, the Court finds the remaining Plaintiffs Drs. Stephen D. Henry, James G. Schwendig, Carmen Kavali, California Medical Association, Medical Association of Georgia, and Connecticut State Medical Society in civil contempt of the court. It is further

ADJUDGED that Drs. Henry, Schwendig, and Kavali be fined in the amount of $100 each per month that they continue to violate this Court's order as coercive sanctions. It is further

ADJUDGED that California Medical Association, Medical Association of Georgia, and Connecticut Medical Society be fined in the amount of $500 per month that they continue to violate this Court's order as coercive sanctions. It is further

ORDERED AND ADJUDGED that:

(1) The Court declines to rule on the issue of compensatory sanctions and attorneys' fees.

(2) WellPoint, Inc.'s Motion for Sanctions (D.E. No. 6313) is GRANTED IN PART and DENIED IN PART.

(3) Provider Plaintiffs' Motion for Stay of Imposition Sanctions (D.E. No. 6316) is DENIED.

(4) Provider Plaintiffs' Motion for Reconsideration (D.E. No. 6327) is DENIED.

DONE AND ORDERED in Chambers at Miami, Florida, this 25 day of July, 2012.

/s/ Federico A. Moreno
FEDERICO A. MORENO
CHIEF UNITED STATES DISTRICT JUDGE

Copies provided to:
Counsel of Record

APPENDIX F

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

[Filed 8/15/2014]

No. 12-14013-CC

IN RE: MANAGED CARE, ET AL.

MEDICAL ASSOCIATION OF GEORGIA, CALIFORNIA MEDICAL ASSOCIATION, CONNECTICUT STATE MEDICAL SOCIETY, STEPHEN D. HENRY, M.D., JAMES G. SCHWENDIG, M.D., CARMEN KAVALI, M.D.,

Plaintiffs-Appellants,

v.

WELLPOINT, INC.,

Defendant-Appellee.

On Appeal from the United States District Court for the Southern District of Florida

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Before: MARTIN and JORDAN, Circuit Judges, and BAYLSON,* District Judge.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no Judge in regular active service on the Court having

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* Honorable Michael M. Baylson, United States District Judge for the Eastern District of Pennsylvania, sitting by designation.

requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure), the Petition(s) for Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/ Beverly B. Martin
United States Circuit Judge

APPENDIX G

SETTLEMENT AGREEMENT

Dated as of

July 11, 2005

By and among

WELLPOINT, INC.,
THE REPRESENTATIVE PLAINTIFFS,
THE SIGNATORY MEDICAL SOCIETIES,
AND CLASS COUNSEL

* * *

13. Release, Covenant Not to Sue, and Bar Order

13.1 Discharge of All Released Claims

(a) Upon the Effective Date, the "Released Parties," which shall include Company and each of its present and former parents, present and former wholly-owned Subsidiaries, present and former divisions and Affiliates and each of their respective current or former officers, directors, employees, agents, insurers and attorneys (and the predecessors, heirs, executors, administrators, legal representatives, successors and assigns of each of the foregoing), and all persons who provided claims processing services, software, proprietary guidelines or technology to Company or its Subsidiaries and Affiliates, and those contracted agents processing claims on their behalf, together with each such person's or entity's predecessors or successors (but only to the extent of such person's

or entity's services and work done pursuant to contract with Company or its Subsidiaries or Affiliates), but excluding all Delegated Entities, shall be released and forever discharged by the Signatory Medical Societies and all Class Members who have not validly and timely requested to Opt-Out of this Agreement, and by their respective heirs, executors, agents, legal representatives, professional corporations, partnerships, assigns, and successors, but only to the extent such claims are derived by contract or operation of law from the claims of Class Members, (collectively, the "Releasing Parties") from any and all causes of action, judgments, liens, indebtedness, costs, damages, obligations, attorneys' fees, losses, claims, liabilities and demands of whatever kind or character (each a "Claim"), arising on or before the Effective Date, that are, were or could have been asserted against any of the Released Parties by reason of, arising out of, or in any way related to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referenced in the Actions, whether any such Claim was or could have been asserted by any Releasing Party on its own behalf or on behalf of other Persons, or to the business practices that are the subject of § 7. This includes, without limitation and as to Released Parties only, any aspect of

any Fee for Service Claim submitted by any Class Member to Company, and any claims of any Class Member related to or based upon any Capitation agreement between Company and any Class Member or other person or entity, or the delay, nonpayment or amount of any Capitation payments by Company, and any allegation that other defendants in the Actions and/or Company have conspired with, aided and abetted, or otherwise acted in concert with other managed care organizations, other health insurance companies, Delegated Entities and/or other third parties with regard to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referred to in the Actions, or with regard to Company's liability for any other demands for payment submitted by any Class Member to such other managed care organizations, health insurance companies, Delegated Entities and/or other third parties.

* * *

14.4 Effective Date

If the Final Order and Judgment is entered by the Court and the time for appeal from all of such orders and judgment has elapsed (including without limitation any extension of time for the filing of any appeal that may result by operation of law or order of the Court) with no notice of appeal having been filed, the "Effective Date" shall be the next business day after

the last date on which notice of appeal could have been timely filed. If the Final Order and Judgment is entered and an appeal is filed as to any of them, the "Effective Date" shall be the next business day after the Final Order and Judgment, is affirmed, all appeals are dismissed, and no further appeal to, or discretionary review in, any Court remains.

* * *

14.6 Termination Date of Agreement

This Agreement shall terminate (the "Termination Date") upon the earlier to occur of (i) termination of this Agreement by any Party pursuant to the terms hereof and (ii) the four-year anniversary of the Preliminary Approval Date. Effective on the Termination Date, the provisions of this Agreement shall immediately become void and of no further force and effect and there shall be no liability under this Agreement on the part of any of the Parties, except for willful or knowing breaches of this Agreement prior to the time of such termination; provided that in the event of a termination of this Agreement as contemplated by clause (ii) of this § 14.6, (a) the provisions of §§ 13.1, 13.2, 13.3, 13.4, 13.5, 13.7 and 13.8 and §§ 15, 16, 17, 18, and 19 shall survive such termination indefinitely, (b) the provisions of § 7.10 and § 7.11 shall survive such termination only with respect to, and only for so long as is necessary to resolve, any Billing Disputes that are in the process of being resolved by the Billing Dispute External Review Board as of the date of such termination and any disputes described in § 7.11 that are being resolved pursuant to the External Review process as of the date of such termination and (c) the provisions of §§ 12.1 through 12.6 shall survive such termination only with respect to, and only for so long as is necessary to

resolve, any Compliance Disputes that are in the process of being resolved by the Compliance Dispute Review Officer as of the date of such termination. On the Termination Date, all of Company's obligations under this Agreement shall be satisfied. Except as provided below in this § 14.6, no decision or ruling of the Compliance Dispute Review Officer shall have any force on the Parties after the Termination Date and Company shall be under no obligation to continue performance of any kind under this Agreement. Company may, in its sole and absolute discretion, elect to continue after the Termination Date, the implementation of various business practices described in this Agreement. Company also may, where it has a good faith basis, and notwithstanding any Implementation Date date in § 7 of this Agreement or in Exhibit G hereto, delay the implementation, in whole or in part, of any provision of this Agreement upon notice to Class Counsel, in which case, and only to the extent that implementation of a provision of this Agreement has been delayed, the term of the Agreement shall be extended with respect to the delayed provision for a period of time equal to the length of the delay. If Class Counsel believe that Company has willfully delayed implementation, in whole or in part, of any material provision of this Agreement without providing notice to Class Counsel pursuant to the preceding sentence, then they may petition the Compliance Dispute Resolution Officer for a recommendation that, to the extent implementation of such a provision was delayed, the term of the Agreement be extended with respect to the delayed provision for a period of time equal to the length of the willful delay. Upon a finding of willful delay and a recommendation by the Compliance Dispute Resolution Officer, Class Counsel may petition the

Court for an extension of the Effective Period equal to the length of the willful delay with respect to the delayed provision, but only to the extent that implementation of such provision was delayed.

* * *

APPENDIX H

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
Miami Division

[Filed 1/3/2006]

MDL No. 1334
Master File No. 00-1334-MD MORENO

IN RE MANAGED CARE LITIGATION

Case No. 04-21589

CHARLES B. SHANE, M.D., *et al*.,
Plaintiffs,

v.

HUMANA INC., *et al.*
Defendants

Case No. 03-21296-CIV-MORENO

KENNETH A. THOMAS, M.D., *et al*.,
Plaintiffs,

v.

BLUE CROSS & BLUE SHIELD ASSOCIATION, *et al*.,
Defendants.

THIS DOCUMENT RELATES ONLY TO
PROVIDER TRACK CASES

AMENDED ORDER APPROVING SETTLEMENT AMONG WELLPOINT, INC. AND PHYSICIANS, PHYSICIAN GROUPS AND PHYSICIAN ORGANIZATIONS, CERTIFYING CLASS AND DIRECTING ENTRY OF FINAL JUDGMENT

* * *

Release and Injunctions Against Released Claims

5. The "Released Parties," which shall include Company and each of its present and former parents, present and former wholly-owned Subsidiaries, present and former divisions and Affiliates and each of their respective current or former officers, directors, employees, agents, insurers and attorneys (and the predecessors, heirs, executors, administrators, legal representatives, successors and assigns of each of the foregoing), and all persons who provided claims processing services, software, proprietary guidelines or technology to Company or its Subsidiaries and Affiliates, and those contracted agents processing claims on their behalf, together with each such person's or entity's predecessors or successors (but only to the extent of such person's or entity's services and work done pursuant to contract with Company or its Subsidiaries or Affiliates), but excluding all Delegated Entities, shall be released and forever discharged by the Signatory Medical Societies and all Class Members who have not validly and timely requested to Opt-Out of this Agreement, and by their respective heirs, executors, agents, legal representatives, professional corporations, partnerships, assigns, and successors, but only to the extent such claims are derived by contract or operation of law from the claims of Class Members, (collectively, the "Releasing Parties") from any and all causes of action, judgments,

liens, indebtedness, costs, damages, obligations, attorneys' fees, losses, claims, liabilities and demands of whatever kind or character (each a "Claim"), arising on or before the Effective Date that are, were or could have been asserted against any of the Released Parties by reason of, arising out of, or in any way related to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referenced in the Actions, whether any such Claim was or could have been asserted by any Releasing Party on its own behalf or on behalf of other Persons, or to the business practices that are the subject of § 7 of the Settlement Agreement. This includes, without limitation and as to Released Parties only, any aspect of any Fee for Service Claim submitted by any Class Member to Company, and any claims of any Class Member related to or based upon any Capitation agreement between Company and any Class Member or other person or entity, or the delay, nonpayment or amount of any Capitation payments by Company, and any allegation that other defendants in the Actions and/or Company have conspired with, aided and abetted, or otherwise acted in concert with other managed care organizations, other health insurance companies, Delegated Entities and/or other third parties with regard to any of the facts, acts, events, transactions, occurrences, courses of conduct, representations, omissions, circumstances or other matters referred to in the Actions, or with regard to Company's liability for any other demands for payment submitted by any Class Member to such other managed care organizations, health insurance companies, Delegated Entities and/or other third parties.

* * *

9. The Releasing Parties are permanently enjoined from: (i) filing, commencing, prosecuting, intervening in, participating in (as class members or otherwise) or receiving any benefits from any lawsuit, arbitration, administrative or regulatory proceeding or order in any jurisdiction based on any or all Released Claims against one or more Released Parties; (ii) instituting, organizing class members in, joining with class members in, amending a pleading in or soliciting the participation of class members in, any action or arbitration, including but not limited to a purported class action, in any jurisdiction against one or more Released Parties based on, involving, or incorporating, directly or indirectly, any or all Released Claims, and (iii) filing, commencing, prosecuting, intervening in, participating in (as class members or otherwise) or receiving any benefits from any lawsuit, arbitration, administrative or regulatory proceeding or order in any jurisdiction based on an allegation that an action taken by Company, which is in compliance with the provisions of the Settlement Agreement, violates any legal right of any member of the Class.

* * *

27. Without in any way affecting the finality of this Order and the Judgment, this Court hereby retains jurisdiction as to all matters relating to (a) the interpretation, administration, and consummation of the Settlement Agreement and (b) the enforcement of the injunctions described in paragraphs 10, 18, and 20 of this Order.

SO ORDERED this 31st day of December, 2005.

/s/ Frederico A. Moreno
HON. FEDERICO A. MORENO
UNITED STATES DISTRICT COURT

c: Service List

APPENDIX I

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

[Filed 12/18/2009]

Master File No. MDL 09-2074

IN RE WELLPOINT, INC. OUT-OF-NETWORK "UCR" RATES LITIGATION

The Hon. Philip S. Gutierrez

FIRST CONSOLIDATED AMENDED COMPLAINT

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* * *

123. Based on these procedures, Ingenix produces two cycles of uniform pricing schedules per year that include medical, surgical, anesthesia and coding system service rates for a given "geo-zip" and applicable CPT code in the form of a price range that shows the charges at various percentage intervals, *e.g.*, 50th, 75th and 90th. For any CPT code and geo-zip combination with less than nine billed charges remaining in the database after deletions by both the contributing insurers and Ingenix, Ingenix instead determines and reports "derived charges." According to Ingenix, "derived charges" are calculated by pooling billed charges for similar services in the same geographic area, and then adjusting that data using

values assigned by Ingenix to account for differences in the complexity and expense of the procedure at issue. The version of the MDR Database offered by Ingenix consists entirely of the resulting "derived charges," which are offered in a similar percentile price range format, ranging from the 25th to the 95th percentiles.

124. Once WellPoint receives these uniform pricing schedules, they are uploaded onto a computerized claims platform and automatically accessed by WellPoint to determine reimbursement amounts for ONS within the range provided by the Ingenix UCR schedules. WellPoint's computer systems then automatically generate reimbursement amounts for ONS claims. In other words, the Ingenix Database is automatically applied and no human intervention is utilized to evaluate the accuracy of the pricing data provided by Ingenix.

125. Similar to its "warning" about the geo-zips, Ingenix also "warns" its customers, including the other Defendants here, it does not formally endorse, approve or recommend the use of the Ingenix data for UCRs. With each production, Ingenix includes the following disclaimer:

> The Ingenix data are provided to subscribers for informational purposes only. Ingenix, Inc. disclaims any endorsements, approval, or recommendation or particular uses of the data. There is neither a stated nor an implied "reasonable and customary charge . . . ."

126. Despite this disclaimer, twice a year, Ingenix provides WellPoint and the Insurer Conspirators with uniform UCR pricing schedules (*i.e.*, False UCRs). Ingenix knows the Ingenix Database is being used by

health insurers for the purpose of determining UCRs and ONS reimbursements. Indeed, the UnitedHealth Defendants promise that Ingenix Database users will achieve substantial cost savings, including a promised 16:1 return on investment. This promise makes sense only if the Ingenix Database is being used to determine ONS reimbursement amounts. The only purpose of the uniform pricing schedule is to establish an artificially low range upon which subscribing insurers base their ONS reimbursement. The False UCR range in the Ingenix schedules thereby serves as an absolute ceiling on the amount the Insurer Conspirators will pay in ONS reimbursement for particular procedures across the country and also as a mechanism to depress ONS reimbursements throughout the insurance industry (*i.e.*, if the entire range reflects artificially low UCRs, then ONS reimbursements based on that range are necessarily artificially low also).

* * *

Plaintiff Dr. Henry

196. Plaintiff Dr. Henry is an internist with a private practice in Pasadena, California. He is licensed to practice medicine in the State of California, and has been certified by the American Board of Internal Medicine, American Board of Emergency Medicine, American Board of Medical Specialties, Subspecialty in Geriatrics, and American Academy of HIV Medicine, HIV Specialist. During the relevant time, Dr. Henry provided ONS to WellPoint's subscribers. ONS fees account for approximately 30-35% of Dr. Henry's annual revenue.

197. Because patients find it difficult to pay out of pocket for medical treatment at the time of service,

they rely on their health plans to reimburse their physicians for their services. While this arrangement is generally beneficial for the patient who does not have to pay for his treatment at the time of service, it leaves the Provider Plaintiffs and members of the Provider Class to advance the cost of such medical treatment until they receive payment from their patients' insurers. To facilitate direct payment from insurers, Dr. Henry's patients sign a form assigning their health benefits to him before treatment. This form includes an express authorization by the patient for insurers, such as WellPoint, to remit payment for "professional services otherwise payable to [the patient] or the holder of the policy" directly to Dr. Henry.

198. At all relevant times, Dr. Henry utilized a HCFA 1500 form, or more recently, a CMS 1500 form, to submit claims to WellPoint for payment. Dr. Henry's claims are routinely submitted electronically. Once an electronic claim is submitted it passes through a clearinghouse before reaching WellPoint. All of Dr. Henry's claims are submitted to WellPoint using CPT codes, Healthcare Common Procedure Coding System ("HCPCS") and modifiers, as necessary. Dr. Henry does not find out his compensation from WellPoint for services rendered until after a procedure is performed and a claim for payment is submitted.

199. At all relevant times, Dr. Henry expected to be reimbursed by WellPoint at the lesser of his billed charges or the current UCR. WellPoint defines UCR as follows:

> A "usual" charge is the amount that is most consistently charged by an individual physician for a given service. A "customary"

> charge is the amount that falls within a specified range of usual charges for a given service billed by most physicians with similar training and experience within a given geographic area. A "reasonable" charge is a charge that meets the Usual and Customary criteria, or is otherwise reasonable in light of the complexity of treatment of the particular case. Under a UCR Program, the payment is the lowest of the actual billed charge, the physician's usual charge or the area customary charge for any given covered service.

200. On September 8, 2008, Dr. Henry provided covered medical services to a patient subscriber of Blue Cross of California, a plan administered by Defendant WellPoint. Dr. Henry submitted the appropriate CMS 1500 (or its equivalent) to WellPoint for payment for these services. On September 19, 2008, Blue Cross of California sent an EOB by U.S. mail to Dr. Henry, informing him that for each of the procedure codes that he submitted "[t]his is the amount in excess of the allowed expense for a non-participating provider. The Health Plan is not responsible for any amounts in excess of this allowed expense." In other words, out of the $289.00 of billed charges submitted by Dr. Henry, Blue Cross of California did not allow payment of $150.60, leaving Dr. Henry out of pocket for his services.

201. On June 19 and 26 of 2008, Dr. Henry provided covered medical services to a patient subscriber of Blue Cross of California, a plan administered by Defendant WellPoint. Dr. Henry submitted the appropriate CMS 1500 (or its equivalent) to WellPoint for payment for these services. On July 7, 2008, Blue Cross of California sent an EOB by U.S. mail to Dr.

Henry, informing Dr. Henry that for each of the procedure codes that he submitted "[t]his is the amount in excess of the allowed expense for a non-participating provider. The Health Plan is not responsible for any amounts in excess of this allowed expense." In other words, out of the $286.00 of billed charges submitted by Dr. Henry, Blue Cross of California did not allow payment of $129.95, leaving Dr. Henry out of pocket for his services.

202. At various times, WellPoint unlawfully diminished Dr. Henry's compensation by improperly calculating UCRs and then misapplying these rates to his claims. Dr. Henry's EOBs and Remittance Advices often state that his billed charges purportedly are "in excess of the allowed expense for a non-participating provider," and that the "Health Plan is not responsible for any amounts in excess of this allowed expense." Nowhere on the EOBs, Remittance Advices or elsewhere in any other correspondence sent to Dr. Henry does WellPoint or its Blue Cross of California subsidiary discuss or identify how it actually calculates UCRs. The EOBs do not even specify whether Ingenix data or some other methodology was used in these calculations.

203. WellPoint's EOBs are intentionally uninformative, false and misleading regarding the use of UCRs. This ambiguity has resulted in the inconsistent ONS reimbursements. WellPoint has repeatedly reimbursed Dr. Henry differently for identical procedures performed within the same timeframe, with no explanation for the discrepancy.

Plaintiff Dr. Schwendig

204. Plaintiff Dr. Schwendig is a trauma surgeon at Scripps Memorial Hospital in La Jolla, California. He

is licensed to practice medicine in the State of California, and has been certified by the American Board of Surgery and National Board of Medical Examiners. At all relevant times, Dr. Schwendig provided ONS (in the form of emergency and trauma healthcare services) to WellPoint subscribers.

205. As an emergency department-based trauma surgeon, Dr. Schwendig is responsible for the initial resuscitation and stabilization of patients. Under California's Health and Safety Code, emergency room doctors are obligated to treat all emergency room patients without regard to whether they are insured or able to pay. Calif. Health & Safety Code §1317. The Code further provides that health plans must pay for emergency medical services (by implication and judicial interpretation at UCRs). Calif. Health & Safety Code §1371.4(b). This is necessary because emergency room patients are in need of immediate care and generally are not in a position to choose their physicians as routine patients do – in other words, in-network or out-of-network considerations do not apply under such circumstances.

206. On September 10 through 18, 2007, Dr. Schwendig provided emergency healthcare services to a patient subscriber of Blue Cross of California, a plan administered by Defendant WellPoint. Dr. Schwendig, through his billing service, submitted the appropriate CMS 1500 (or its equivalent) to WellPoint for payment for these services. On September 29, 2007, Blue Cross of California sent an EOB by U.S. mail to Dr. Schwendig informing him that for each of the procedure codes that he submitted "[t]his is the amount in excess of the allowed expense for a non-participating provider." In other words, out of the $2,234.00 in billed charges submitted by Dr.

Schwendig, Blue Cross of California did not allow $708.23. On October 19, 2007, Dr. Schwendig appealed this underpayment by letter sent by U.S. mail, which stated that "[t]here is an amount of $708.23, denied as 'over allowed amount', that remains to be paid. According to our records, no contract exists between Dr. James Schwendig and Blue Cross that would obligate him to accept your "allowed amount" as payment in full for his services. Please re-process this claim for payment of the full billed charge amount as soon as possible. Please also keep in mind that this was a Trauma/Emergency situation and the patient had no choice of physicians." On November 19, 2007, Blue Cross of California reprocessed the claims and sent a second EOB by U.S. mail to Dr. Schwendig. This time, Blue Cross of California paid an additional amount for the patient's co-insurance, but nothing more for the disallowed amounts, stating the same basis for the underpayment determination. As a result of WellPoint's improper ONS determination, Dr. Schwendig was forced to send his patient to collections to recover the $708.23 of his billed charges, but the patient has not paid this amount and Dr. Schwendig remains out of pocket for this amount.

207. Dr. Schwendig's patients are typically unable to make an "assignment of benefits" prior to treatment. Nevertheless, WellPoint routinely acknowledges an assignment of benefits by sending EOBs and remitting payment directly to Dr. Schwendig for services rendered. At times, however, and for no apparent reason, WellPoint will send payment to the patient instead, forcing Dr. Schwendig to attempt to recoup his lawful reimbursement from the patient. This presents a significant hardship for trauma surgeons like Dr. Schwendig who rarely treat their patients on a long-term basis; continued treatment is

generally delivered by specialists or the patient's primary care physician. Trauma surgeons like Dr. Schwendig may never see their patients after discharge.

208. At all relevant times, Dr. Schwendig utilized a HCFA 1500 form, or more recently, a CMS 1500 form, to submit claims for payment to WellPoint. Dr. Schwendig's claims are routinely submitted electronically. Once an electronic claim is submitted, it passes through a clearinghouse before reaching WellPoint. All of Dr. Schwendig's claims are submitted using CPT codes, HCPCS and modifiers, as necessary. Dr. Schwendig does not find out his compensation from WellPoint for services rendered until after a procedure is performed and a claim for payment is submitted.

209. Rather than simply pay Dr. Schwendig the lesser of his billed charges or UCRs, WellPoint routinely and deliberately reimbursed his claims at the False UCR levels, requiring him to expend significant amounts of time and energy identifying and appealing improperly reimbursed claims. As a result, WellPoint unlawfully diminished Dr. Schwendig's compensation by improperly calculating UCRs and misapplying these faulty rates to his claims. Dr. Schwendig's EOBs and Remittance Advices often state that his billed charges purportedly are "in excess of the allowed expense for a non-participating provider." Nowhere on the EOBs, Remittance Advices or elsewhere in any other correspondence sent to Dr. Schwendig does WellPoint discuss or identify how it actually calculates UCR. The EOBs do not even specify whether Ingenix data or some other methodology was used in these calculations.

210. Upon identifying improper payment of a claim by WellPoint, Dr. Schwendig—through his medical billing service, Practice Development Strategies ("PDS")—promptly appealed the determination by sending a formal letter asking WellPoint to reprocess the claim for additional payment. Dr. Schwendig has appealed several of WellPoint's claims determinations in this regard. Each appeal letter sent by PDS on Dr. Schwendig's behalf states that "no contract exists between Doctor James Schwendig and Blue Cross that would obligate him to accept WellPoint's 'allowed amount' as payment in full for his services," and further explains that "this was a Trauma/Emergency situation and the patient had no choice of physicians." In addition to sending these appeals letters, PDS made telephone calls on Dr. Schwendig's behalf to WellPoint to appeal the insurer's wrongful determinations. Dr. Schwendig has repeatedly exhausted any administrative appeals available through WellPoint without succeeding in obtaining full and proper reimbursement for his services.

* * *

Plaintiff Dr. Kavali

240. Plaintiff Carmen Kavali, M.D., is a plastic surgeon with a private practice in Atlanta, Georgia. Dr. Kavali is board certified by the American Board of Plastic Surgery and serves on the staff of Northside Hospital and the Center for Plastic Surgery. She is a citizen of the state of Georgia and is licensed to practice medicine in Georgia. Dr. Kavali does not currently participate in the WellPoint physician network and sees WellPoint patients only on a non-participating basis.

241. Dr. Kavali previously entered into a Provider Agreement with WellPoint entity Blue Cross Blue Shield of Georgia and, as a result, became a member of the WellPoint provider network. On July 25, 2007, Dr. Kavali sent both a fax and a certified letter notifying WellPoint that she was terminating the contract and that she understood the termination would become effective as soon as possible but no later than ninety days after WellPoint's receipt of the letter. As a result, on or before October 23, 2007, Dr. Kavali was no longer a participant in the WellPoint network and thus, with respect to WellPoint, had the status of a non-participating physician thereafter.

242. Throughout the relevant time, Dr. Kavali provided out-of-network healthcare services to WellPoint plan enrollees. Dr. Kavali's experience with WellPoint's unlawful business practices is typical of what has happened to the Provider Class as a whole.

243. Before and no later than October 23, 2007, Dr. Kavali treated patients with coverage under plans covered or administered by WellPoint on an out-of-network basis. In each case, Dr. Kavali has obtained from the patient signed Assignment of Benefits form. Customarily, before Dr. Kavali performs a procedure for these patients, her office staff will contact WellPoint to confirm coverage, the lack of a pre-certification requirement, inquire about the basis upon which payment to her will be made, and ask for the amount of the payment so that the patient's share of the cost can be calculated. WellPoint, however, customarily refuses to explain the basis upon which payment will be made and will not disclose the amount that Dr. Kavali will receive. The only information that WellPoint typically will disclose is the amount of the

patient's co-insurance, the out-of-network deductible, and how much of the deductible has already been met.

244. After receipt of Dr. Kavali's claim for medical services, WellPoint customarily will send to her or to her patient an EOB (such as a "Provider Explanation of Medical Benefits Report," "Remittance Advice" or similar explanation of benefits) that specifies the amount being paid for each of the services that were provided. In each instance, the EOB shows that the amount paid by WellPoint has been less than the billed charge. WellPoint has given various explanations for its decision not to pay the full amount, such as "this charge has been processed based upon the provider's participation status and your contract terms."

245. On November 6, 2007, Dr. Kavali provided covered medical services to patient E.P. Dr. Kavali obtained an Assignment of Benefits from the patient before providing treatment. On December 13, 2007 Dr. Kavali mailed through the U.S. mail to BCBS of Georgia, a WellPoint subsidiary, a complete and clean HCFA form submitting CPT 19357. CPT Code 19357 indicates that the procedure involved a "breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion." Her submitted charge was $6,240. After applying the patient's $31.82 deductible and $32.01 coinsurance amounts, BCBS reduced Dr. Kavali's $6,240 submitted charge by $4,586.28. BCBS allowed payment of $1,589.89 rather than $6,176.17.

246. On or about January 10, 2008, BCBS sent through the U.S. mail to Dr. Kavali and/or her patient an EOB for services provided on November 6, 2007 for patient E.P. The EOB provided no explanation for the

reduction of benefits. Dr. Kavali did not bill patient E.P. for said service.

247. On December 4, 2007, Dr. Kavali provided covered medical services to patient S.B. Dr. Kavali obtained an Assignment of Benefits from the patient before providing treatment. On or about December 4, 2007, Dr. Kavali mailed through the U.S. mail to BCBS of Georgia, a WellPoint subsidiary, a complete and clean HCFA form submitting CPT Code 19370-50. CPT Code 19370 indicates that the procedure involved an "open periprosthetic capsulotomy, breast." Modifier 50 was used to indicate that the procedure was bilateral. Her submitted charge was $6,500. After applying the patient's $370.31 coinsurance amount, BCBS reduced Dr. Kavali's $6,500 submitted charge by $5,265.65. BCBS allowed payment of $864.04 rather than $4,550.

248. On or about January 4, 2008, BCBS sent through the U.S. mail to Dr. Kavali and/or her patient an EOB for services provided on December 4, 2007 for patient S.B. The EOB did not provide an explanation for the reduction of benefits. Dr. Kavali did not balance-bill patient S.B. for said service.

249. By using the Ingenix Database to calculate the amount she receives for her services, WellPoint and its subsidiaries improperly and unlawfully diminished the compensation to which Dr. Kavali is entitled. Because she typically is unable to collect from her patients the full amount of her billed charges, Dr. Kavali has been injured monetarily as a direct and proximate result of WellPoint's improper conduct.

250. The EOBs issued by WellPoint relating to the out-of-network patients treated by Dr. Kavali do not provide any procedures or process by which to appeal

the amount of compensation. Even if the EOBs are received by Dr. Kavali, which typically they are not, it is unclear if the adjudication may be appealed or if so, how. The EOB-related documents simply contain a statement that "if you have any questions, please call" and a toll free telephone number is given. A website to "view eligibility, benefits or claim details online" is provided.

251. Dr. Kavali understands from the information she does receive from WellPoint that, as an out-of-network provider, it is not necessary to file a written appeal to WellPoint. WellPoint only provides appeal procedures to participating providers. Dr. Kavali or her staff has telephoned WellPoint entities to complain about the amounts of compensation paid for a particular service without any success in obtaining additional payment.

252. Any further appeal to WellPoint regarding the amount of her compensation would have been futile as WellPoint did not disclose and, indeed, concealed its use of the Ingenix Database to diminish payments based upon UCRs and routinely asserted that it was paying the proper amount due under the patient's plan. Further, it would have been inconsistent with WellPoint's scheme to disclose to physicians such as Dr. Kavali as part of any appeal process that it was manipulating the calculation of UCRs or to provide additional compensation to physicians as such additional payments would have constituted an admission of its improper conduct.

* * *

CLASS ALLEGATIONS

342. Plaintiffs bring this action on behalf of themselves and all others similarly situated, pursuant

to Rule 23(a), (b)(2) and (b)(3) of the Federal Rules of Civil Procedure. Plaintiffs seek to represent the following Classes:

The Subscriber Class

> All persons or entities enrolled in a health plan administered or insured by WellPoint who paid for ONS from a non-participating Physician or other healthcare provider and received reimbursement in an amount less than the billed charges on or after January 1, 1999.

The Provider Class

> All non-participating physicians who provided ONS to any member of any health plan administered or insured by WellPoint, other than through the Empire subsidiaries, at any time since September 29, 2006, and were paid less than their billed charges for such services; and all other non-participating healthcare providers who provided ONS, to any member of any health plan administered or insured by WellPoint, who were paid less than their billed charges for such services on or after January 1, 1999.

The Antitrust Injunctive Relief Class

> All persons or entities enrolled in a health plan that includes out-of-network health insurance coverage and is administered or insured by WellPoint and all non-participating physicians and other non-participating healthcare providers who provide or have provided ONS to any such persons or entities.

The ERISA Subscriber Subclass

All persons or entities enrolled in ERISA-governed health insurance plans administered by WellPoint who paid for ONS and received reimbursement in an amount less than the billed charges on or after January 1, 1999.

The ERISA Provider Subclass

All Physicians who provided services to and accepted a valid assignment from any person enrolled in an ERISA-governed health insurance plan administered or insured by WellPoint, other than through the Empire subsidiaries, and were paid less than their billed charges for such services on or after September 29, 2006; and Other Healthcare Providers who provided services to and accepted a valid assignment from any person enrolled in an ERISA-governed health insurance plan administered or insured by WellPoint and were paid less than their billed charges for such services on or after January 1, 1999.

The Non-ERISA Subscriber Subclass

All persons enrolled in a non-ERISA individual and/or family health plan administered or insured by WellPoint who paid for ONS from a Physician or Healthcare Provider and received in an amount less than the billed charges on or after January 1, 1999.

The Non-ERISA Provider Subclass

All Physicians who provided services to a member of the Non-ERISA Subscriber

Subclass, other than those who were enrolled in a plan administered or insured by an Empire subsidiaries, and who accepted an assignment of benefits and were paid less than their billed charges for such services on or after September 29, 2006; and all other healthcare Providers who provided services to a member of the Non-ERISA Subscriber Subclass, accepted an assignment of benefits and were paid less than their billed charges on or after January 1, 1999.

* * *

APPENDIX J

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

[Filed 10/17/2011]

Master File No. MDL 09-2074

IN RE WELLPOINT, INC.
OUT-OF-NETWORK "UCR" RATES LITIGATION

The Hon. Philip S. Guitierrez

THIRD CONSOLIDATED AMENDED COMPLAINT

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* * *

114. In or around 2005, members of HIAA (which by then had changed its name to AHIP), including WellPoint, discussed submitting more than these four data points to Ingenix because they expressly recognized the four data points were inadequate to calculate accurate UCRs. On information and belief, these discussions were triggered by lawsuits challenging the UCRs. Around this same time, Ingenix actually asked WellPoint to submit more data points. WellPoint never did so, yet when its contract with Ingenix was renewed in 2008, it continued to receive license fee waivers ranging from 50% to 100%. Despite this express acknowledgement, Defendants and the Conspirators agreed to continue only to submit the four above-listed elements to Ingenix. Defendants and the Conspirators understood and agreed that Ingenix

would continue to base UCRs on the same insufficient data points it had always been using. By that decision, Defendants and their Conspirators affirmatively determined to continue to enter and submit only the four data points. In doing so, they also affirmatively determined to continue to ignore other material information relevant (and indeed crucial to) pricing, including, but not limited to:

(a) where the services were rendered (*i.e.*, doctor's office, trauma center, clinic, hospital, nursing home, *etc.*);

(b) what type of provider performed the service (*i.e.*, licensed specialist, general practitioner, nurse practitioner, *etc.*);

(c) the number of providers of the service in the specific geographic area at issue;

(d) the level of experience or training of the provider;

(e) the complexity of the procedure under the circumstances or the existence of special circumstances as reported on the claim form in a standard code known as a modifier;

(f) the resources expended to perform the procedure as reported on the claim form in a standard code known as a modifier;

(g) age or condition of the patient; and

(h) cost-of-living adjustments, if any.

* * *

APPENDIX K

[LOGO]

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August 29, 2014

BY ELECTRONIC FILING

John Ley, Clerk of Court
U.S. Court of Appeals for the 11th Circuit
56 Forsyth St., N.W.
Atlanta, Georgia 30303

Re: *Musselman v. Blue Cross Blue Shield of Alabama*
Case No. 13-14250-AA
Fed. R. App. P. 28(j)
Notice of Supplemental Authority
(Oral Argument Scheduled for Sept. 11, 2014)

Dear Mr. Ley:

Defendants-Appellees submit this letter to make sure the Panel is aware of *Medical Association of Georgia v. WellPoint, Inc*., No. 12-14013 (11th Cir. June 18, 2014), *pet. for rehearing denied* (Aug. 15, 2014) ("*MAG*"), which will be discussed at oral argument.

In a 2-1 decision, *MAG* affirmed Chief Judge Moreno's determination in another case that one of the Releases at issue in this case applies to antitrust claims based on alleged conspiracies that began before the Effective Date of the Release. In so doing, *MAG* specifically rejected the argument that a plaintiff can circumvent the Release by "seek[ing] to base the new claims on certain conduct post-dating the Effective Date . . . ." Slip Op. at 27. Instead, it held that such alleged conduct is "best seen as new, overt acts within an ongoing conspiracy, rather than new claims in and of themselves." *Id*.

MAG applies directly to Appellants' argument in this case that the Releases do not apply to the antitrust claims in *Conway* because they are based on conduct that occurred after the Effective Dates of the Releases. It confirms that Judge Moreno did not abuse his discretion when he held that "even if Plaintiffs limit their claims for services provided after the Effective Dates, the claims are still released." Dismissal Order at 13-14 (D.E. 66). Judge Moreno based this holding on his identical conclusion in *MAG*, *see id*. at 13 (citing "*Shane* D.E. 6116"), which the Eleventh Circuit affirmed in relevant part.[1] Judge Moreno held below that "[t]he antitrust claims in *Conway* are based on an alleged conspiracy dating back to long before the Effective Dates," and "[a]s a result, Plaintiffs could have asserted these claims before" the settlement. *Id*. In *MAG*, the Eleventh Circuit agreed with Judge Moreno's identical reasoning in that case. *See MAG* Slip Op. at 27. Thus, MAG controls here. Accordingly, as in *MAG*, this

[1] *MAG* reversed Judge Moreno's separate conclusion that the Release barred ERISA claims based on alleged underpayments after the Effective Date. *See* Slip Op. at 29-31.

Court should affirm Judge Moreno's holding that Appellants' antitrust claims are released.

Respectfully submitted,

HOGAN LOVELLS US LLP

By: /s/ Peter R. Bisio
Peter R. Bisio

Coordinating Counsel for Appellees

cc: All Counsel of Record (by electronic notice of filing)